No. 96-110-CFX Title: Washington, et al., Petitioners
v.
Harold Glucksberg, et al.

Docketed: July 19, 1996 Court: United States Court of Appeals for the Ninth Circuit

See also:
95-1858

Entry	Date	Proceedings and Orders
	May 14 1996	Application (A95-919) to extend the time to file a petition for a writ of certiorari from June 4, 1996 to August 3, 1996, submitted to Justice O'Connor.
	May 14 1996	Application (A95-919) granted by Justice O'Connor extending the time to file until July 4, 1996.
	May 29 1996	Application (A95-974) for a stay of the mandate pending the filing and disposition of a petition for a writ of certiorari, submitted to Justice O'Connor.
	May 29 1996	(A95-974) Upon consideration of the application of counsel for the applicants, It is Ordered that the mandate of the United States Court of Appeals for the Ninth Circuit, case No. 94-35534, issued on May 29, 1996, be recalled and stayed pending receipt of a response, due on or before June 5, 1996, and further order of the undersigned or of the Court.
	May 30 1996	Response to application (A95-974) filed by Harold Glucksberg, et al.,.
	Jun 5 1996	Application (A95-974) referred to the Court by Justice O'Connor.
	Jun 10 1996	Application (A95-974) granted by the Court. The application for a stay of the issuance of the mandate of the United States Court of Appeals for the ninth circuit, case No. 94-35534, issued on May 29, 1996, presented to Justice O'Connor and by her referred to the Court is granted pending the timely filing and disposition by this Court of a petition for a writ of certiorari. Should the petition for a writ of certiorari be denied, this stay terminates automatically. In the event the petiiton for a writ of certiorari is granted, this stay shall continue pending the sending down of the judgment of this Court.
	Jul 3 1996	Petition for writ of certiorari filed. (Response due August 18, 1996)
	Jul 3 1996	Appendix of petitioners filed.
	Aug 7 1996	Brief amici curiae of California, et al. filed.
	Aug 16 1996	Brief of respondents Harold Glucksberg, et al. in opposition filed.
	Aug 19 1996	Motion of American Medical Association, et al. for leave to file a brief as amici curiae filed.
	Aug 28 1996	DISTRIBUTED. September 30, 1996
	Aug 29 1996	Reply brief of petitioners Washington, et al. filed.
	Sep 9 1996	Supplemental brief of respondents filed.
	Oct 1 1996	Motion of American Medical Association, et al. for leave

HPP

Entry	Date	Proceedings and Orders
		to file a brief as amici curiae GRANTED.
	Oct 1 1996	Petition GRANTED. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, November 12, 1996. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 10, 1996. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, December 27, 1996. Rule 29.2 does not apply. The case is set for oral argument in tandem with No. 95-1858, Vacco v. Quill. SET FOR ARGUMENT January 8, 1997.
		**********
	Nov 7 1996	Brief amici curiae of Gary Lee, et al. filed. VIDED.
	Nov 7 1996	Brief amici curiae of Members of the New York and Washington State Legislatures filed. VIDED.
	Nov 7 1996	LODGING consisting of eleven copies of Vol.12, No.2 of Issues in Law and Medicine submitted by counsel for the amici Gary Lee, et al.
	Nov 8 1996	Brief amici curiae of California, et al. filed.
	Nov 8 1996	Brief amici curiae of United States Catholic Conference, et al. filed.
	Nov 12 1996	Joint appendix filed.
	Nov 12 1996	Brief of petitioners Washington, et al. filed.
	Nov 12 1996	Motion of Schiller Institute for leave to file a brief as amicus curiae filed.
	Nov 12 1996	Brief amicus curiae of District Attorney of Milwaukee County, Wisconsin filed.
	Nov 12 1996	Brief amicus curiae of National Right to Life Committee, Inc. filed.
	Nov 12 1996	Brief amici curiae of Legal Center for Defense of Life, Inc., et al. filed.
	Nov 12 1996	Brief amicus curiae of Oregon filed.
	Nov 12 1996	Brief amici curiae of American Medical Association, et al. filed.
	Nov 12 1996	Brief amicus curiae of Southern Center for Law and Ethics filed.
	Nov 12 1996	Brief amicus curiae of The Rutherford Institute filed.
	Nov 12 1996	Brief amicus curiae of American Suicide Foundation filed.
	Nov 12 1996	LODGING consisting of ten copies of a report entitled "Physician-Assisted Suicide and Euthanasia in the Netherlands" to the HR Judiciary Committee, Sept. 1996 submitted by counsel for the amicus American Suicide Foundation.
	Nov 12 1996	Brief amicus curiae of National Spinal Cord Injury Association, Inc. filed.
	Nov 12 1996	Brief amicus curiae of United States filed.
	Nov 12 1996	Brief amicus curiae of National Hospice Organization filed. VIDED.
	Nov 12 1996	LODGING consisting of one paperbound book entitled, "Dying Well" submitted by counsel for the amicus,

No. 96-110-CFX

Entry	Date	Proceedings and Orders
		National Hospice Organization.
	Nov 12 1996	Brief amicus curiae of American Geriatrics Society filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Catholic Health Association of the United States filed. VIDED.
	Nov 12 1996	Brief amici curiae of Natl. Catholic Office for Persons With Disabilities, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Richard Thompson, Prosecuting Attorney of Oakland County filed. VIDED.
	Nov 12 1996	Brief amici curiae of Senator Orrin Hatch, et al. filed. VIDED.
	Nov 12 1996	LODGING consisting of ten copies of Serial No. 78, entitled Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution, April 29, 1996 submitted by counsel for amici, Orrin Hatch, et al.
	Nov 12 1996	Brief amicus curiae of International Anti-Euthanasia Task Force filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American Hospital Association filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Bioethic Professors filed. VIDED.
	Nov 12 1996	Brief amici curiae of National Association of Prolife Nurses, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Family Research Council filed. VIDED.
	Nov 12 1996	LODGING consisting of ten copies of pamphlet entitled Issues in Law and Medicine submitted by counsel for amicus, Family Research Council
	Nov 12 1996	Brief amicus curiae of Project on Death In America, Open Society Institute filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Agudath Israel of America filed. VIDED.
	Nov 12 1996	Brief amici curiae of American Assn. of Homes and Services for the Aging, et al. filed. VIDED.
	Nov 12 1996	Brief amici curiae of Institute for Public Affairs of UOJCA, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Catholic Medical Association filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American Center for Law & Justice filed. VIDED.
	Nov 12 1996	Brief amici curiae of Natl. Legal Ctr. for Medically Dependent & Disabled, et al. filed. VIDED.
	Nov 12 1996	Brief amici curiae of Christian Legal Society, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American College of Legal Medicine filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Evangelical Lutheran Church in America filed. VIDED.
	Nov 15 1996	CIRCULATED.
	Dec 9 1996	Motion of Schiller Institute for leave to file a brief as amicus curiae GRANTED.
	Dec 9 1996	Brief amici curiae of Council for Secular Humanism, et al. filed.

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Entry	Date	Proceedings and Orders
	Dec 9 1996	Motion of Wayne County, Michigan for leave to file a brief as amicus curiae filed.
	Dec 9 1996	Brief amicus curiae of Surviving Family Members in Support of Physician-Assisted filed. VIDED.
	Dec 10 1996	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Dec 10 1996	Brief of respondents Harold Glucksberg, Abigail Halperin, T. Preston & P. Shalit filed.
	Dec 10 1996	Brief amici curiae of Gay Men's Health Crisis, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Julian Whitaker filed. VIDED.
	Dec 10 1996	Brief amici curiae of Washington State Psychological Assn., et al. filed. VIDED.
	Dec 10 1996	Brief amici curiae of Ronald Dworkin, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Center for Reproductive Law & Policy filed.
	Dec 10 1996	Brief amici curiae of American Medical Student Association, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of State Legislators filed.
	Dec 10 1996	Brief amici curiae of American Civil Liberties Union, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Coalition of Hospice Professionals filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Bioethicists filed. VIDED.
	Dec 10 1996	Brief amici curiae of Americans for Death With Dignity, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Law Professors filed. VIDED.
	Dec 10 1996	Brief amici curiae of 36 Religious Organizations, Leaders and Scholars filed. VIDED.
	Dec 10 1996	LODGING consisting of one copy of "Dying With Dignity FAQS" submitted by counsel for amici Washington State Psychological Assn., et al.
	Dec 16 1996	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Dec 16 1996	Motion of Wayne County, Michigan for leave to file a brief as amicus curiae GRANTED.
	Dec 16 1996	Record filed.
	Dec 17 1996	Record filed.
	Dec 24 1996	Motion of John Doe for leave to file a brief as amicus curiae filed.
	Dec 26 1996	Reply brief of petitioners Washington, et al. filed.
	Jan 6 1997	Video tape Exhibit, Document 17, from USDC for WD WA received.
	Jan 8 1997	ARGUED.
	Jan 13 1997	Motion of John Doe for leave to file a brief as amicus curiae DENIED.

FILED

96 110 JUL 3 1996

OFFICE OF THE CLERK

No.

IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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HOPE

QUESTIONS PRESENTED

1. Is there a constitutionally protected liberty interest under the Due Process Clause of the Fourteenth Amendment in committing suicide, and if so, does that interest include assistance in so doing?

2. If the answer to the foregoing question is in the affirmative, is a State statute that infringes on the protected liberty interest by prohibiting one person from assisting another to commit suicide nonetheless valid under the Due Process Clause because it furthers legitimate State interests?

3. Is there a rational basis for distinguishing between refusing life-sustaining medical treatment and requesting life-ending medical intervention, so that a State whose law allows the former but not the latter does not violate the Equal Protection Clause of the Fourteenth Amendment?

LIST OF PARTIES

The parties to the proceeding below were:

Petitioners: State of Washington and Christine O. Gregoire, Attorney General of Washington, both of whom were aligned as defendants/appellants below.

Respondents: Harold Glucksberg, M.D., Abigail Halperin, M.D., Thomas A. Preston, M.D., and Peter Shalit, M.D., Ph.D., all of whom were aligned as plaintiffs/respondents below. Three individuals identified only by pseudonyms were plaintiffs in the District Court below, but died during the pendency of the proceedings and are no longer parties to the litigation. A nonprofit corporation, Compassion in Dying, was a plaintiff in the District Court; however, its claims were not adjudicated by the District Court order that prompted this appeal and it is not a party to the appeal.

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PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

The Petitioners respectfully pray that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit, filed March 6, 1996.

OPINIONS BELOW

The decision of the *en banc* panel of the United States Court of Appeals for the Ninth Circuit[1] is reported at 79 F.3d 790 (9th Cir. 1996). The Court's Amended Order[2] denying a request that the full court rehear the case *en banc*, with dissenting opinions, is reported at ___ F.3d ___ (1996 WL 315922) (9th Cir. 1996). The decision of the Ninth Circuit three judge panel[3] is reported at 49 F.3d 586 (9th Cir. 1995). The decision of the United States District Court for the Western District of Washington[4] is reported at 850 F. Supp. 1454 (W.D. Wash. 1994).

JURISDICTION

The Court of Appeals' opinion was filed and judgment entered on March 6, 1996.[5] The jurisdiction of

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[1] *Compassion in Dying* II, App. at A-1 to A-164. The copy of the opinion reflects changes pursuant to the *en banc* panel's order amending the opinion filed May 28, 1996. A copy of this order is found in the appendix at page B-1.

[2] *Compassion in Dying* I, App. at C-1 to C-26.

[3] App. at D-1 to D-27.

[4] App. at E-1 to E-29.

[5] App. at A-1.

this Court is invoked pursuant to 28 U.S.C. § 1254(1). By order of May 14, 1996, the time for filing an application for a writ of certiorari was extended to July 4, 1996.[6]

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. Constitution, Fourteenth Amendment

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Declaratory Judgment Act, 28 U.S.C. § 2201

> (a) In a case of actual controversy within its jurisdiction, except with respect to Federal taxes other than actions brought under section 7428 of the Internal Revenue Code of 1986, a proceeding under section 505 or 1146 of title 11, or in any civil action involving an antidumping or countervailing duty proceeding regarding a class or kind of merchandise of a free trade area country (as defined in section 516A(f)(10) of the Tariff Act of 1930), as determined by the administering authority, any court of the United States, upon the filing of an

[6] App. at F-1 to F-2.

> appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.
>
> (b) For limitations on actions brought with respect to drug patents see section 505 or 512 of the Federal Food, Drug, and Cosmetic Act.

Washington Revised Code § 9A.36.060

> (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.
>
> (2) Promoting a suicide attempt is a class C felony.

STATEMENT OF THE CASE

The jurisdiction of the District Court was invoked pursuant to 28 U.S.C. § 2201 and 42 U.S.C. § 1983. Eight plaintiffs—three patients, four physicians, and a nonprofit corporation—filed suit seeking a declaratory judgment that Washington's criminal statute prohibiting one person from aiding another person to commit suicide violates the Fourteenth Amendment of the United States Constitution. Plaintiffs also sought to enjoin enforcement of the statute.

1. The Statutory Scheme At Issue

Washington's statute prohibiting one person from assisting another person to commit suicide was initially adopted in 1854 by the first Territorial Legislature. The prohibition has remained in effect throughout the State's history, although the specific language of the statute has

varied with different codifications of the State's criminal code.[7]

The 1975 revision of the criminal code retained the prohibition against assisted suicide while at the same time removing criminal penalties from the act of attempting suicide.[8] The legislative committee whose comprehensive study led to the revision explained:

> "[W]hatever may be said of suicide itself, it seems clear that the introduction into the situation of another person who actively promotes the suicide could well increase the instability or irrationality of the potential suicide, affecting his judgment or emotional outlook. . . . Whatever the thoughts of a potential suicide may be, it is almost inconceivable that the threat of a two year prison sentence if he is unsuccessful in his attempt is going to deter his act. Moreover, it seems clear that such a person is in all probability a troubled, disturbed human being who need[s] psychiatric care or some other counseling service. His condition could only be aggravated by being branded a convicted felon and sent to [prison] for

[7] Copies of the various legislative enactments, including the statute currently in effect, are found in the appendix at pages G-1 to G-3.

[8] *See* Washington Laws of 1975, 1st Ex. Sess., ch. 249, § 9A.92.010 (214) (repealing former Wash. Rev. Code § 9.80.020, which was originally enacted by Washington Laws of 1909, ch. 249, § 134).

> two years. Thus no attempted suicide crime is defined by this [proposed] code."[9]

In 1991, Washington's voters rejected Initiative 119, which, had it passed, would have authorized a form of physician aid in dying.[10] Its enactment also would have presumably created an implied exception to the crime of promoting or aiding a suicide, at least for conduct explicitly authorized by the initiative. The initiative did not expressly amend or repeal the assisted suicide statute at issue here.

Almost all other States also prohibit assisting a suicide, either by statutes or by case law.[11] These statutes—generally considered part of the States' homicide laws—have been recognized by this Court as evidencing the States' interest in protecting and preserving human life.[12]

[9] Legislative Council's Judiciary Committee, *Report on the Revised Washington Criminal Code* 153 (December 3, 1970).

[10] A copy of the initiative is found in the appendix at pages H-1 to H-10. The initiative was prepared in standard legislative drafting form, reflecting changes in the existing statutory language by underlining language to be added and striking language to be deleted, enclosing the latter in double parentheses.

[11] In his dissent from the *en banc* panel decision, Judge Beezer catalogued forty-four States that condemn assisted suicide. *See* App. at A-135 to A-136, n.10-13. The list is extensive, but not exhaustive, because States are continuing to grapple with the issue. Judge Beezer's list does not include, for example, the 1995 Louisiana statute prohibiting "criminal assistance to suicide". *See* La. Rev. Stat. § 14:32.12 (as amended by Louisiana Acts of 1995, No. 384, § 1. It should also be noted that the Model Penal Code includes a prohibition against aiding suicide. Model Penal Code § 210.5.

[12] *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261, 280 (1990).

2. The Proceedings Below

a. The District Court Opinion

On cross motions for partial summary judgment, the District Court held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide."[13] Finding that Washington's statute prohibiting assisted suicide places an "undue burden" on the exercise of that right, the District Court concluded that the statute violates the Due Process Clause of the Fourteenth Amendment.[14]

The District Court also held that persons who depend on life support systems to remain alive are situated similarly to those who are terminally ill but able to continue living without life support, and that the refusal or withdrawal of life support by the former is "equivalent" to assisted suicide.[15] The District Court concluded that by allowing withdrawal or withholding life support, but prohibiting assisted suicide, Washington law violates the Equal Protection Clause as well.[16] Based on these conclusions, the District Court declared the statute unconstitutional.[17]

The District Court granted final judgment declaring the statute invalid pursuant to Fed. R. Civ. P. 54(b) and 28 U.S.C. § 2201, addressing only the claims of the patient

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[13] App. at E-16 (footnote omitted).

[14] App. at E-24.

[15] App. at E-28.

[16] *Id.*

[17] App. at E-28 to E-29.

plaintiffs and those advanced on their behalf by the physician plaintiffs.[18] The District Court did not reach the claims of the nonprofit corporation, nor the claims of the physicians on their own behalf, as they were not argued to the District Court.[19] The District Court declined to grant injunctive relief.[20]

b. The Court Of Appeals Panel Decision

Petitioners appealed to the Court of Appeals pursuant to 28 U.S.C. § 1291. A majority of a three judge panel of the Court of Appeals reversed the District Court, finding that the "decision of the district court lacks foundation in recent precedent [and] in the traditions of our nation."[21] Even assuming the existence of a liberty interest, the panel recognized several State interests furthered by the statute and concluded that "Washington's interests . . . individually and convergently, outweigh any alleged liberty of suicide."[22]

Rejecting the District Court's equal protection analysis, the panel also held that "plaintiffs have not sustained [their] burden"[23] of demonstrating that there is no rational basis for Washington's statutory distinction

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[18] App. at I-1 to I-3.

[19] App. at E-28.

[20] App. at E-29.

[21] *Compassion in Dying* I, App. at D-13.

[22] App. at D-14.

[23] App. at D-19.

"between actions taking life and actions by which life is not supported."[24] Senior Judge Wright dissented.[25]

c. ***En Banc* Review**

Respondents' suggestion for *en banc* review was granted[26] and a limited *en banc* panel was convened pursuant to 28 U.S.C. § 46(c) and Ninth Circuit Rule 35-3. Following oral argument, a majority of the *en banc* panel "clarified" the scope of the District Court opinion and then affirmed.[27] Rather than declaring the entire statute invalid, the *en banc* panel held that the "or aids" portion of the Washington statute violates the Due Process Clause when applied to the prescription of medications to assist adult persons who are mentally competent and terminally ill in committing suicide.[28]

Three judges dissented. Judge Beezer concluded that mentally competent, terminally ill adults have a liberty interest in committing physician-assisted suicide, but that the State's interests "are sufficiently strong to sustain the constitutionality of RCW 9A.36.060 as applied to plaintiff's asserted liberty interest."[29] Judges Fernandez and Kleinfeld, in separate opinions, concurred with Judge

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[24] App. at D-18.

[25] App. at D-20 to D-27.

[26] *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995).

[27] *Compassion in Dying* II, App. at A-19.

[28] App. at A-19 to A-20.

[29] App. at A-160.

Beezer, but added that they found no constitutionally protected interest in committing suicide.[30]

d. **Post-Decision Proceedings**

The Court of Appeals' *sua sponte* suggestion for rehearing before the full court failed to receive a majority of the votes of the non-recused active judges of the Ninth Circuit.[31] Pursuant to orders of this Court, the Ninth Circuit's mandate has been stayed pending disposition of this petition.[32]

REASONS FOR GRANTING THE PETITION

Petitioners agree with the opening two sentences of the *en banc* panel opinion:

> "This case raises an extraordinarily important and difficult issue. It compels us to address questions to which there are no easy or simple answers, at law or otherwise."[33]

Citing such diverse authorities as Plato,[34] Shakespeare,[35] and the Harris Poll,[36] a majority of the

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[30] App. at A-160 (Fernandez, J., dissenting); A-161 to A-164 (Kleinfeld, J., dissenting).

[31] App. at C-1.

[32] App. at K-1 to K-2.

[33] App. at A-3.

[34] App. at A-41.

[35] App. at A-75.

[36] App. at A-48 to A-49.

Ninth Circuit *en banc* panel held that mentally competent, terminally ill adult patients have interests protected under the Due Process Clause of the Fourteenth Amendment and that these interests include a liberty interest in obtaining physician assistance in ending their lives.

At first blush, the Ninth Circuit appears to have narrowed the scope of the District Court's decision. Rather than declaring the entire statute invalid, the ruling by its terms applies only to the "or aids" provision, and then only to circumstances involving physician prescription of medications for terminally ill patients.[37]

On closer reading, however, it becomes clear that the Ninth Circuit ruling is in many respects much broader than that of the District Court. Thus, not only does it apply to physicians, but also to other health care workers, family members, and friends.[38] Though the purported liberty interest is described in terms of avoiding pain, the *en banc* panel suggests that the desire to avoid medical bills may be sufficient to implicate constitutional protection.[39] Nor is the Ninth Circuit decision limited to those who are mentally competent: "[A] decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself."[40] Finally, the Ninth Circuit decision telegraphs the possibility that in future cases the "right to die" may expand to "other forms of life-

[37] App. at A-19 to A-20.

[38] App. at A-116, n.140.

[39] App. at A-87.

[40] App. at A-100 to A-101, n.120.

ending medical assistance, such as the administration of drugs by a physician"—i.e., active euthanasia.[41]

1. The Ninth Circuit's Opinion Conflicts With Established Supreme Court Jurisprudence

The Supreme Court has historically found constitutional protection to apply to those liberties "'implicit in the concept of ordered liberty [such that] neither liberty nor justice would exist if [they] were sacrificed.'"[42] In an alternative formulation, this Court described interests entitled to constitutional protection as those that are "deeply rooted in this Nation's history and tradition."[43]

In deciding whether particular conduct is constitutionally protected, this Court has looked not to broad categories of activities, or even to the ends the activities seek to accomplish, but rather to the specific conduct at issue in the case before the Court. As the Court has recently cautioned, "'[s]ubstantive due process' analysis must begin with a careful description of the asserted right".[44]

[41] App. at A-100; *see also* A-30, n.15 ("The constitutionality of prohibiting physicians from administering life-ending drugs to terminally ill persons is not before us.").

[42] *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937)).

[43] *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977).

[44] *Reno v. Flores*, 507 U.S. 292, 302 (1993) (*citing Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992)).

Thus, for example, this Court has concluded that marriage[45] and the use of contraceptives[46] are constitutionally protected. These are but two means toward the end of controlling the makeup of one's family. But other means to that end—polygamy and infanticide, for example—are not the subject of constitutional protection.

Similarly, liberty interests in refusing unwanted medical treatment[47] or having access to abortion services[48] have not been transformed to a broader liberty interest in controlling all activities affecting one's body,[49] an end that could include prostitution and recreational drug use.

Disregarding this cautionary approach, the Ninth Circuit majority took the opposite approach. Its inquiry was not limited to the more narrow issue before it—whether there is a liberty interest in committing suicide that includes assistance in doing so. Instead, the Ninth Circuit addressed the broader question of "whether there is a liberty interest in determining the time and manner of one's death," or "the right to die."[50] As Judge Reinhardt,

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[45] *Turner v. Safely*, 482 U.S. 78 (1987).

[46] *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

[47] *See, e.g., Washington v. Harper*, 494 U.S. 210 (1990).

[48] *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

[49] The *Roe* Court declined an invitation to rule "that one has an unlimited right to do with one's body as one pleases." *Roe*, 410 U.S. at 154.

[50] App. at A-27.

writing for the majority, explained: "[I]t is the end and not the means that defines the liberty interest."[51]

The Ninth Circuit's conclusion departed from this Court's jurisprudence by selectively reading fragments of the *Cruzan* and *Casey* decisions without reference to their holdings or the larger context in which they were decided. It then compounded its error by applying the wrong test.

a. *Cruzan*

In *Cruzan v. Missouri Department of Health*,[52] this Court considered whether there were constitutional limitations on the procedural requirements a State could impose prior to granting a request that artificial life support be withdrawn from a comatose patient who had no hope of recovery.

The *Cruzan* Court acknowledged that its prior decisions recognized a liberty interest in refusing unwanted medical treatment.[53] The Court further assumed, but specifically did not decide, that withdrawal of mechanically administered nutrition and hydration was encompassed within such a liberty interest.[54]

The *Cruzan* Court then held that Missouri's imposition of procedural safeguards to assure that such a

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[51] *Id.*

[52] *Cruzan v. Missouri Dep't of Health*, 497 U.S. 261 (1990).

[53] *Cruzan*, 497 U.S. at 278 (1990). Given that providing unwanted medical treatment without consent was a tort at the common law, it is difficult to argue that such a liberty interest is not "deeply rooted in this Nation's history and traditions". *Moore*, 431 U.S. at 503.

[54] *Cruzan*, 497 U.S. at 279.

decision was made voluntarily did not violate the Fourteenth Amendment.[55] Such procedural safeguards were justified on the basis of at least two important State interests—preserving life, and protecting against undue influence or abuse.[56]

With respect to the State's interest in preserving life, the *Cruzan* Court noted that:

> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide."[57]

The *Cruzan* Court rejected the notion that a State's interest in protecting and preserving an individual's life varies proportionately to the quality of that life:

> "[A] State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life[.]"[58]

The Ninth Circuit turned *Cruzan* on its head. Even though the *Cruzan* Court only *assumed* a liberty interest in refusing artificial food and hydration, the *en banc* panel

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[55] *Id.* at 283.

[56] *Id.* at 280.

[57] *Id.* at 280.

[58] *Id.* at 282.

concluded that *Cruzan* "necessarily recognizes a liberty interest in hastening one's own death."[59]

The Ninth Circuit opinion acknowledged the *Cruzan* Court's admonition that "the state's interest in preserving life may be unqualified, and may be asserted regardless of the quality of the life or lives at issue."[60] But it nonetheless concluded that the "*strength* [of the state's interest] is dependent on relevant circumstances, including the medical condition . . . of the person whose life is at stake."[61]

The *en banc* panel majority does not disclose how, under its formulation, a State legislature is to assess the *strength* of the State's interest in protecting life in individual situations without making "judgments about the 'quality' of life that a particular individual may enjoy"[62]—precisely the judgments that the *Cruzan* Court said a State is not required to make.

Finally, the Ninth Circuit decision converted *Cruzan*'s approval of a State's procedural safeguards surrounding end of life decisions to a purported holding that "the state could not prohibit" such decisions altogether.[63] Regardless of how this Court might decide that question—were it presented—nothing in the *Cruzan* opinion suggests that it was presented or answered in the

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[59] App. at A-62 (footnote omitted).

[60] App. at A-65 (citing *Cruzan*).

[61] *Id.* (emphasis in original).

[62] *Cruzan*, 497 U.S. at 282.

[63] App. at A-59, n.67; *see also* A-104.

Cruzan case. This conversion of what "may" be done into what "must" be done is precisely the kind of sophistry that this Court criticized in *Cruzan*.[64]

b. *Casey*

The Ninth Circuit also misapplied this Court's holding in *Planned Parenthood v. Casey*.[65] The issue in that case was whether to narrow or overturn the holding in *Roe v. Wade*[66] that a woman's decision to terminate a pregnancy was constitutionally protected. In *Casey*, a majority of the Court concluded that "the essential holding of *Roe v. Wade* should be retained and once again reaffirmed."[67]

The Ninth Circuit decision below expanded the *Casey* holding into a reformulation of the standard by which the existence of constitutionally protected liberty interests are to be determined. It read introductory language describing a category of previously recognized liberty interests as a pronouncement that any activities

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[64] Two prior Supreme Court decisions held that a State may require that parents make certain decisions on behalf of their minor children. Apparently, Ms. Cruzan's parents contended that these decisions stood for the proposition that a State must recognize parental decisionmaking. The *Cruzan* Court noted that "petitioners would seek to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking. But constitutional law does not work that way." *Cruzan*, 497 U.S. at 286.

[65] 505 U.S. 833 (1992).

[66] 410 U.S. 113 (1973).

[67] *Casey*, 505 U.S. at 846.

falling within the grammatical construct of this categorization is now subject to constitutional protection.[68]

Such a reading ignores the context in which *Casey* was decided, its solid grounding in the doctrine of *stare decisis*, and the following explicit language in Justice O'Connor's opinion:

> "Abortion is a *unique* act. [In the abortion context] the liberty of the woman is at stake in a sense unique to the human condition and so *unique* to the law."[69]

c. The Appropriate Test

The Ninth Circuit *en banc* panel expressly held that the "'or aids' provision of [the] Washington statute . . . is unconstitutional *as applied* to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physician."[70]

By attempting to limit its holding to a single category of those subject to the statute, the Ninth Circuit finessed the test announced in *United States v. Salerno*[71] for determining facial[72] challenges to statutes under the

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[68] *See generally*, App. at A-54 to A-58.

[69] *Casey*, 505 U.S. at 852 (emphasis added).

[70] App. at A-113 to A-114 (emphasis added). As noted above at pages 10-11, the import of the decision may be much broader.

[71] 481 U.S. 739 (1987).

[72] The District Court analyzed Respondents' complaint as challenging the statute on its face. App at E-16 to E-20. On appeal, Respondents re-framed their challenge, attacking the statute "as applied" to the group for whom they advocate. Both they and the

Due Process Clause, i.e., whether there is "no set of circumstances . . . under which the Act would be valid."[73] The *Salerno* Court pointed out that "we have not recognized an 'overbreadth' doctrine outside the limited context of the First Amendment."[74]

The Ninth Circuit attempted to defend its approach by acknowledging that "[d]eclaring a statute unconstitutional as applied to members of a group is atypical but not uncommon."[75] However, the two cases it cites do not support this proposition. The first[76] involved a statute purporting to authorize government conduct that violated the Fourth Amendment. It was the conduct, and not the statute, that was at issue. The second[77] was a First Amendment case; its holding clearly was consistent with the "overbreadth" doctrine recognized by the *Salerno* Court as an exception to the general rule.

The Ninth Circuit instead applied its own version of a balancing test, relying on *Cruzan* and two cases cited by

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Ninth Circuit appear to agree that the statute serves legitimate State interests in all other circumstances to which it applies—i.e., situations involving those who are mentally or emotionally disturbed, those not terminally ill (however defined), and those who, though mentally competent and terminally ill, wish to live.

[73] *Salerno*, 481 U.S. at 745.

[74] *Id.*

[75] App. at A-20, n.9.

[76] *Tennessee v. Garner*, 471 U.S. 1 (1985).

[77] *Wisconsin v. Yoder*, 460 U.S. 205 (1972).

the *Cruzan* Court.[78] All three of these cases involved the application of State law to particular fact situations involving identified individuals.

At issue in the instant case is a legislative judgment about the appropriate scope of the Washington enactment, not its application to particular individuals. Labeling this case as involving a challenge to the statute "as applied" is a misnomer.

State legislatures must have the discretion to assess the needs of various segments of their respective populaces, balance competing interests, and craft legislation that reflects that balance, so long as the enactment serves a legitimate purpose as to at least some of those to whom it is addressed.

It is the essential nature of this legislative process that the interests of some are subordinated to further what the legislature deems to be a greater benefit to others or to society as a whole. As this Court has recently noted:

> "Even laws enacted for broad and ambitious purposes often can be explained by reference to legitimate public policies which justify the incidental disadvantages they impose on certain persons."[79]

Application of the *Salerno* rule to cases such as this—regardless of the label applied to them—allows States to continue this essential legislative function, so long as the choices they make further legitimate State interest in at

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[78] *Youngberg v. Romeo*, 457 U.S. 307 (1982), and *Mills v. Rogers*, 457 U.S. 291 (1982), cited in *Cruzan*, 497 U.S. at 279.

[79] *Romer v. Evans*, ___ U.S. ___, 116 S. Ct. 1620, 1628 (1996).

least some of the circumstances to which they are addressed.

This Court should grant certiorari to correct the Ninth Circuit's erroneous reading of its prior decisions and to give guidance as to the appropriate test to be applied when statutes of general application are challenged under the Due Process Clause.

2. The Ninth Circuit Due Process Conclusion Conflicts With Those Of Other Appellate Courts That Have Considered The Issue

The Ninth Circuit is the only appellate court in this or any other country[80] to hold that a statute prohibiting assisted suicide violates the Due Process Clause. It stands in conflict with decisions of State appellate courts in Michigan and California, and with a recent decision of the Second Circuit.

The Michigan Supreme Court, in a series of related cases involving the well-known Dr. Kevorkian,[81] affirmed the Michigan Court of Appeals in rejecting the argument that a State ban on assisted suicide violates the Due Process Clause:

> "[T]he right to commit suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this nation's history and

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[80] The Supreme Court of Canada has rejected a claim that section 7 of the Canadian Charter of Rights and Freedoms, a provision that parallels the Due Process Clause, mandates allowing assisted suicide. *Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (1993).

[81] For a detailed account of the activities of Dr. Kevorkian—the so-called suicide doctor—see Michael Betzold, *Appointment With Dr. Death* (1993).

> tradition. It would be an impermissibly radical departure from existing tradition, and from the principles that underlie that tradition, to declare that there is such a fundamental right protected by the Due Process Clause."[82]

This Court denied certiorari.[83] The California Court of Appeals has also rejected the notion that the Due Process Clause protects a liberty interest in assisted suicide.[84]

The most recent appellate court in this country to consider the issue is the Second Circuit Court of Appeals, which also declined to find that a State prohibition against assisted suicide violates the Due Process Clause.[85]

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[82] *People v. Kevorkian*, 447 Mich. 436, 481, 527 N.W.2d 714 (1994). The Michigan Supreme Court reversed the holding of the Michigan Court of Appeals that the statute at issue had been enacted in violation of procedural requirements of the Michigan Constitution, but upheld the Court of Appeals' alternative holding that the statute did not violate the Due Process Clause. *See Hobbins v. Attorney General*, 205 Mich. App. 194, 518 N.W.2d 487 (1994).

[83] *Kevorkian v. Michigan*, 115 S. Ct. 1795 (1995).

[84] "In the case of assisted suicides, however, the state has an important interest to ensure that people are not influenced to kill themselves. The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."

Donaldson v. Lundgren, 4 Cal. Rptr. 2d 59, 64, 2 Cal. App. 4th 1614 (Cal. App. 2d Dist. 1992).

[85] *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (Petition for Certiorari pending). The *Quill* court's holding that New York statutes similar to Washington's violate the Equal Protection Clause is discussed below.

> "The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death."[86]

In short, the Ninth Circuit is the *only* appellate court to conclude that a statute prohibiting assisting a suicide violates the Due Process Clause.

This Court should grant certiorari to resolve the conflict created by the erroneous decision below.

3. The Equal Protection Clause Does Not Support The Conclusion Reached Below

The District Court advanced the Due Process Clause and the Equal Protection Clause as alternative bases for concluding that the Washington statute is unconstitutional.[87] The panel decision rejected both.[88]

The Ninth Circuit *en banc* panel, having concluded that the statute violates the Due Process Clause, ostensibly did not consider the equal protection prong of the District Court's analysis.[89]

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[86] *Id.* at 724-25.

[87] App. at E-28.

[88] *Compassion in Dying* I, App. at D-18 to D-19.

[89] App. at A-115. Even though not relied on by the *en banc* panel, Respondents' equal protection arguments are properly considered in connection with this Petition For Certiorari as Respondents "may legitimately defend their judgment on any ground properly raised below." *Reno*, 507 U.S. at 300, n.3 (1993).

A closer reading of the opinion below reveals, however, that equal protection principles played an integral part in its due process analysis. This is most apparent in the *en banc* panel's assessment of the strength of Washington's interest in enforcing the statute in individual situations involving the terminally ill. That analysis is based largely on the existence of Washington's Natural Death Act,[90] a statute authorizing the withholding or withdrawing of life support from terminally ill persons in some circumstances. According to the Ninth Circuit majority:

> "In adopting the statute, the Washington legislature necessarily determined that the state's interest in preserving life is not so weighty that it ought to thwart the informed desire of a terminally ill, competent adult to refuse medical care."[91]

The court then proceeded from this premise to a conclusion that Washington's interests in prohibiting assisted suicide were equally weak:

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[90] Wash. Rev. Code §§ 70.122.010-.120.

[91] App. at A-66. The Ninth Circuit majority did not explain why the Natural Death Act could not simply be viewed as a legislative choice among many competing interests in the difficult circumstances to which the Natural Death Act is addressed. Nor did the majority explain how its assessment of legislative intent could be squared with the following explicit language from the Natural Death Act:

> Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

Wash. Rev. Code § 70.122.100.

> "[W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . [W]e find the state's interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention. To the extent that a difference exists, we conclude that it is one of degree and not of kind."[92]

The equal protection analysis implicit in the Ninth Circuit's conclusion was explicitly the basis for the Second Circuit's recent decision that two New York laws substantially similar to the Washington statute were invalid.[93] According to the Second Circuit, "New York does not treat similarly circumstanced persons alike"[94] and the distinction is "not rationally related to any legitimate state interest."[95]

This conclusion was predicated on the same two flawed premises underlying the District Court's equal protection analysis in the instant case—that persons who depend on life support systems to remain alive are situated similarly to those who are able to eat, drink, and breathe

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[92] App. at A-82.

[93] *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (Petition For Certiorari pending).

[94] *Id.* at 729.

[95] *Id.* at 731.

on their own; and that refusing or withdrawing life support by the former is "equivalent" to assisted suicide.[96]

Other courts that have addressed the issue of withholding or withdrawing life-sustaining treatment, including artificial hydration and nutrition, have reached the opposite conclusion. Most of these cases recognized the difference between refusing unwanted medical treatment and suicide, the act of refusing life itself.[97]

Consider the following examples:

The Washington State Supreme Court:

> "We emphasize that we are not endorsing suicide or euthanasia."[98]

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[96] App. at E-18. The District Court's analysis was also predicated on the erroneous proposition that the "strict scrutiny" test applied to the statute. App. at E-25. The *Quill* Court recognized, correctly, that statutes not implicating fundamental rights or involving suspect classifications are to be overturned only if there is no rational basis for the statutory classification. *Quill*, 80 F.3d at 727.

[97] *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court of Los Angeles (Glendale Adventist Med. Ctr.)*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220 (1984); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720 (Conn. Super. Ct. 1984); *Staz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978); *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651, 652 (1989); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626, 638 (1986); *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404, 411 (1987); *Matter of Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 273, 420 N.E.2d 64, 71, n.6 (1981); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc. 1, 426 N.E.2d 809, 815 (1980); *In re Grant*, 109 Wn.2d 545, 563, 747 P.2d 445 (1987).

[98] *In re Grant*, 109 Wn.2d at 563.

The New Jersey Supreme Court:

> "We would see, however, a real distinction between the self-infliction of deadly harm [suicide] and a self-determination against artificial life support . . . ."[99]

The Arizona Supreme Court:

> "Asserting the right to refuse medical treatment is not tantamount to committing suicide."[100]

The Maine Supreme Court :

> "[A patient's] decision not to receive [medical procedures], far from constituting suicide, is a choice to allow to take its course the natural dying process set in motion by his physiological inability to chew or swallow."[101]

In short, the equal protection analysis that is explicit in *Quill* and implicit in the *en banc* panel decision is at odds with virtually every appellate court decision addressing end of life issues.

4. This Case Presents Important Issues Of Public Policy And Federalism

This case is important because its subject matter—physician assisted suicide—is hotly debated in

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[99] *In the Matter of Quinlan*, 355 A.2d at 665.

[100] *Rasmussen v. Fleming*, 154 Ariz. at 218.

[101] *In re Gardner*, 534 A.2d at 955-56 (citations omitted).

hospital corridors and legislative halls across the nation. A constitutional "right to die"—if it exists—has implications for every American.

Two States—Michigan and New York—have commissioned studies of the assisted suicide issue, each producing thoughtful analyses of the complex set of medical, philosophical, ethical, social, and legal interests that the subject evokes.[102] The fact that these analyses arrived at opposite conclusions evidences the complexity of the issue.

But this case has implications far beyond the subject of assisted suicide. The Ninth Circuit's reasoning, if allowed to stand, portends a substantially redefined relationship between the federal judiciary and the States, whose legislatures have historically been viewed as the appropriate venue in a democratic society for resolving important issues of social policy.

This Court has repeatedly cautioned that federal judicial review of State legislation under the Fourteenth Amendment is limited to assuring that it is rationally related to legitimate State interests.[103] As this Court recently noted:

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[102] The New York State Task Force On Life And The Law, *When Death Is Sought: Assisted Suicide And Euthanasia In The Medical Context* (1994); The Michigan Commission On Death And Dying, *Final Report* (1994).

[103] *See, e.g., Williamson v. Lee Optical of Oklahoma*, 348 U.S. 483 (1955); *Ferguson v. Skrupa*, 372 U.S. 726 (1963) ("The [state] statute may be wise or unwise. But relief, if any be needed, lies not with us but in the body constituted to pass laws for the State . . .", 372 U.S. at 732).

> "The Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended."[104]

This restrained jurisprudential approach gives the States latitude to craft legislation that balances the various competing interests affected by a particular issue.

The Ninth Circuit opinion, if allowed to stand, trumpets a substantially more intrusive role for federal courts in reviewing State legislation. Under its approach, State statutes that impose general rules that rationally advance legitimate State interests across a continuum of conduct will not stand. Rather, under the Ninth Circuit's construct, federal courts must examine each application of a State statute and determine whether the State's interest in that particular application is sufficiently strong to outweigh other interests that may be involved. Such balancing of interests, we are told, "is quintessentially a judicial role . . . no legislative body can perform the task."[105]

The question of whether some form of physician assisted suicide should be allowed is a controversial issue of social policy implicating a wide range of interests. The Ninth Circuit decision not only purports to find a constitutionally compelled resolution of that issue, it does so in a manner that significantly enlarges the role of the federal judiciary in resolving other such issues. For both of these reasons, this is a case of exceptional importance, warranting review by this Court.

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[104] *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992).

[105] App. at A-111.

CONCLUSION

In addressing an important issue of social policy, the Ninth Circuit has departed from the traditional approach adopted by this Court and misapplied this Court's prior holdings, creating an expansive and intrusive role for the federal judiciary in reviewing State statutes. Its explicit due process holding conflicts with that of every other appellate court that has considered the issue, and its implicit equal protection decision suffers from the same flaw as that of the only other appellate court to reach the same conclusion.

For all these reasons, this Court should grant the Petition for Writ of Certiorari and reverse the decision of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted this 3rd day of July, 1996.

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IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

COMPASSION IN DYING, a Washington nonprofit corporation; JANE ROE; JOHN DOE; JAMES POE, HAROLD GLUCKSBERG, M.D., *Plaintiffs-Appellees*, v. STATE OF WASHINGTON; CHRISTINE GREGOIRE, Attorney General of Washington, *Defendants-Appellants*.	No. 94-35534 D.C. No. CV-94-119-BJR OPINION

Appeal from the United States District Court
for the Western District of Washington
Barbara J. Rothstein, Chief District Judge, Presiding

Argued and Submitted
December 7, 1994—Seattle, Washington

Filed March 9, 1995

Order Granting Rehearing En Banc
August 1, 1995

Argued and Submitted
October 26, 1995—San Francisco, California

Filed March 6, 1996

Before: James R. Browning, Procter Hug, Jr., Mary M. Schroeder, Betty B. Fletcher, Harry Pregerson, Stephen Reinhardt, Robert R. Beezer, Charles Wiggins, David R. Thompson, Ferdinand F. Fernandez, and Andrew J. Kleinfeld, Circuit Judges.

Opinion by Judge Reinhardt; Dissent by Judge Beezer; Dissent by Judge Fernandez; Dissent by Judge Kleinfeld.

SUMMARY

Individual Rights/Constitutional Rights/Privacy

Sitting en banc, the court of appeals affirmed a district court judgment. The court held that a provision of a Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause.

A Washington state statute provides that a person is guilty of promoting a suicide when he or she knowingly causes "or aids" another person to attempt suicide. Under the statute, aiding a person who wishes to end his or her life constitutes a criminal act and subjects the aider to the possibility of a lengthy prison term, even if the recipient of the aid is a terminally ill, competent adult and the aider is a licensed physician who is providing medical assistance at the patient's request.

Appellees Jane Roe, John Doe, and James Poe (collectively, the patients) desired to obtain prescription drugs to hasten death. The patients were described as mentally competent and in the terminal phase of an illness. Along with four physicians who treat terminally ill patients and appellee Compassion in Dying, a Washington non-profit organization, the patients challenged the Washington statute's "or aids" provision both on its face and as applied to terminally ill, mentally competent adults who wish to hasten their own deaths with the help of medication prescribed by their doctors. The plaintiffs contended that the provision impermissibly prevented the exercise by

terminally ill patients of a constitutionally-protected liberty interest in violation of the Fourteenth Amendment's Due Process Clause, and that it impermissibly distinguished between similarly situated terminally ill patients in violation of the Equal Protection Clause. The district court granted the physicians standing to assert the rights of their terminally ill patients in general.

The district court held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide." The court concluded that the Washington statute placed an undue burden on the exercise of that constitutionally-protected liberty interest and held that the law also violated the Equal Protection Clause. It appeared that the court declared the statute invalid only insofar as it applied to the prescription of medication to terminally ill competent adults who wish to hasten their deaths.

A panel of the court of appeals reversed, holding that there is no due process liberty interest in physician-assisted suicide. The court also concluded that the statute did not violate the Equal Protection Clause. The majority of the panel held that the statute was not invalid facially or as applied. The court of appeals decided to rehear the case en banc.

[1] The doctors met standing requirements because they ran a severe risk of prosecution under the Washington statute, which proscribed conduct in which they sought to engage.

[2] The majority opinion of the panel erroneously concluded that historical analysis alone was sufficient basis for rejecting the plaintiffs' claim to a substantive liberty interest or right. [3] In addition, in recent years, there has been increasingly widespread support for allowing the terminally ill to hasten their deaths and avoid painful,

undignified, and inhuman endings to their lives. **[4]** The now recognized right to refuse or terminate treatment and the emergent right to receive medical assistance in hastening one's death are inevitable consequences of changes in causes of death, medical advances, and development of new technologies. **[5]** Examination of prior Supreme Court decisions demonstrated that there was a strong liberty interest in determining how and when one's life shall end. **[6]** Few decisions are more personal, intimate, or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive, protracted pain. **[7]** Like the decision of whether or not to have an abortion, the decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice that is "central to personal dignity and autonomy." **[8]** A Supreme Court case stands for the proposition that there is a due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means. **[9]** Court cases provide persuasive evidence that the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death — that there is a constitutionally recognized "right to die." **[10]** There is a liberty interest in determining the time and manner of one's death.

[11] Although the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he or she be permitted to die without further medical treatment. **[12]** In addition, the state's interest in preventing suicides in general is substantially diminished in the case of terminally ill, competent adults who wish to die; **[13]** the state has acknowledged that terminally ill persons are entitled in a whole variety of circumstances to

hasten their deaths, and that in such cases their physicians may assist. **[14]** The state's interests in preventing suicide do not make its interest substantially stronger in this case than in cases involving other forms of death-hastening medical intervention. **[15]** Sufficient safeguards can and will be developed by the state and medical profession to ensure that the possibility of error will ordinarily be remote. **[16]** While the state has an interest in preventing the exercise of undue, arbitrary, or unfair influences over an individual's decision to end his life, **[17]** given the possibility of undue influence that already exists, the recognition of the right to physician-assisted suicide would not increase that risk unduly. **[18]** The state's interest in safeguarding the interests of innocent third parties is of almost negligible weight when the patient is terminally ill and his or her death is imminent and inevitable. **[19]** Although the state has a legitimate interest in assuring the integrity of the medical profession, the integrity of the medical profession would not be threatened in any way by the vindication of the liberty interest at issue in this case. **[20]** Although recognition of a right creates the possibility of abuse, there was no reason to believe that legalizing assisted suicide would lead to the horrific consequences suggested by opponents; **[21]** purported definitional difficulties provided no legitimate reason for refusing to recognize a liberty interest in hastening one's death.

[22] The Washington statute prohibiting assisted suicide has a drastic impact on the terminally ill. By prohibiting physician assistance, it bars what for many terminally ill patients is the only palatable, and the only practical, way to end their lives. **[23]** For many terminally ill patients, the Washington statute is effectively a prohibition. **[24]** Although state laws or regulations governing physician-assisted suicide are necessary and desirable to ensure against errors and abuse and to protect legitimate state

interests, [25] Washington, by adopting appropriate, reasonable, and properly drawn safeguards, could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all requisite standards. [26] There was an extensive body of legal, medical, and sociological literature lending support to the conclusion that a prohibition on physician assistance imposes an onerous burden on terminally ill, competent adults who wish to hasten their deaths.

[27] No matter how much weight could legitimately be afforded the state's interest in preventing suicide, that weight, when combined with the weight given all of the other state interests, was insufficient to outweigh the terminally ill individual's interest in deciding whether to end his or her agony and suffering by hastening the time of his or her death with medication prescribed by his or her physician. The individual's interest in making the decision is compelling. Thus, the "or aids" provision of the Washington statute was unconstitutional as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.

Circuit Judge Beezer dissented, stating that he would hold that the mentally competent, terminally ill adults do not have a fundamental right to physician-assisted suicide, but rather an ordinary, nonfundamental, liberty interest in doing so. Circuit Judge Beezer further stated that because the statute at issue rationally advanced four legitimate governmental purposes, it did not violate the plaintiffs' constitutional substantive due process rights. Circuit Judge Beezer also stated that he would hold that the statute does not violate the plaintiffs' constitutional equal protection rights.

Circuit Judge Fernandez dissented, joining in Circuit Judge Beezer's dissenting opinion with a caveat. Circuit

Judge Fernandez stated that he was not convinced that there is any constitutional right to commit suicide.

Circuit Judge Kleinfeld dissented, joining in Circuit Judge Beezer's dissenting opinion, with two qualifications. Circuit Judge Kleinfeld stated that it did not need to be decided whether suicide is a constitutionally protected right.

COUNSEL

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OPINION

REINHARDT, Circuit Judge:

I.

This case raises an extraordinarily important and difficult issue. It compels us to address questions to which there are no easy or simple answers, at law or otherwise. It requires us to confront the most basic of human concerns -- the mortality of self and loved ones -- and to balance the interest in preserving human life against the desire to die peacefully and with dignity. People of good will can and do passionately disagree about the proper result, perhaps even more intensely than they part ways over the constitutionality of restricting a woman's right to have an abortion. Heated though the debate may be, we must determine whether and how the United States Constitution applies to the controversy before us, a controversy that may touch more people more profoundly than any other issue the courts will face in the foreseeable future.

Today, we are required to decide whether a person who is terminally ill has a constitutionally-protected liberty interest in hastening what might otherwise be a protracted, undignified, and extremely painful death. If such an interest exists, we must next decide whether or not the state of Washington may constitutionally restrict its exercise by banning a form of medical assistance that is frequently requested by terminally ill people who wish to die. We first conclude that there is a constitutionally-protected liberty interest in determining the time and manner of one's own death, an interest that must be weighed against the state's legitimate and countervailing interests, especially those that relate to the preservation of human life. After balancing the competing interests, we conclude by answering the narrow question before us: We hold that insofar as the Washington statute prohibits physicians from

prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment.

II.

Preliminary Matters and History of the Case

This is the first right-to-die case that this court or any other federal court of appeals has ever decided.[1] The plaintiffs are four physicians who treat terminally ill patients, three terminally ill patients, and a Washington non-profit organization called Compassion In Dying.[2] The four physicians — Dr. Harold Glucksberg, Dr. Thomas A. Preston, Dr. Abigail Halperin, and Dr. Peter Shalit — are respected doctors whose expertise is recognized by the state. All declare that they periodically treat terminally ill, competent adults who wish to hasten their deaths with help from their physicians. The doctors state that in their professional judgment they should provide that help but are deterred from doing so by a Washington statute that makes it a felony to knowingly aid another person to commit suicide.

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[1] The Second Circuit currently has before it a similar case: *Quill v. Vacco*, No. 95-7028 (2d Cir.). The district court in that case, *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994), held that terminally ill, competent adult patients do not have a fundamental substantive due process right to physician-assisted suicide and that the New York statutes that prohibit assisted-suicide while permitting terminally ill patients to reject life-sustaining treatment do not violate the Equal Protection Clause.

[2] Compassion In Dying provides information, counseling, and assistance to mentally competent, terminally ill adult patients considering hastening their deaths. It also provides similar services to the families of such patients. *Compassion In Dying v. State of Wash.*, 850 F. Supp. 1454, 1458 (W.D. Wash. 1994).

Under the Washington statute, aiding a person who wishes to end his life constitutes a criminal act and subjects the aider to the possibility of a lengthy term of imprisonment, even if the recipient of the aid is a terminally ill, competent adult and the aider is a licensed physician who is providing medical assistance at the request of the patient. The Washington statute provides in pertinent part: "A person is guilty of promoting a suicide attempt when he knowingly causes *or aids* another person to attempt suicide." RCW 9A.36.060 (emphasis added). A violation of the statute constitutes a felony punishable by imprisonment for a maximum of five years and a fine of up to $10,000. RCW 9A.36.060(2) and 9A.20.020(1)(c).

On appeal, the four plaintiff-doctors asserted the rights of terminally ill, competent adult patients who wished to hasten their deaths with the help of their physicians so that they might die peacefully and with dignity. That group included the three patient-plaintiffs. The district court described the patient-plaintiffs, each of whom desired to obtain prescription drugs to hasten his death, as follows:

> Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. In November 1993, her doctor referred her to hospice care. Only patients with a life expectancy of less than six months are eligible for such care.
>
> Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully

alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.

Jane Roe is mentally competent and wishes to hasten her death by taking prescribed drugs with the help of Plaintiff Compassion in Dying. In keeping with the requirements of that organization, she has made three requests for its members to provide her and her family with counseling, emotional support, and any necessary ancillary drug assistance at the time she takes the drugs.

John Doe is a 44-year-old artist dying of AIDS. Since his diagnosis in 1991, he has experienced two bouts of pneumonia, chronic, severe skin and sinus infections, grand mal seizures and extreme fatigue. He has already lost 70% of his vision to cytomegalovirus retinitis, a degenerative disease which will result in blindness and rob him of his ability to paint. His doctor has indicated that he is in the terminal phase of his illness.

John Doe is especially cognizant of the suffering imposed by a lingering terminal illness because he was the primary caregiver for his long-term companion who died of AIDS in June of 1991. He also observed his grandfather's death from diabetes preceded by multiple amputations as well as loss of vision and hearing. Mr. Doe is mentally competent, understands there is no cure for AIDS and wants his physician to prescribe drugs which he can use to hasten his death.

James Poe is a 69-year-old retired sales representative who suffers from emphysema, which causes him a constant sensation of suffocating. He

> is connected to an oxygen tank at all times, and takes morphine regularly to calm the panic reaction associated with his feeling of suffocation. Mr. Poe also suffers from heart failure related to his pulmonary disease which obstructs the flow of blood to his extremities and causes severe leg pain. There are no cures for his pulmonary and cardiac conditions, and he is in the terminal phase of his illness. Mr. Poe is mentally competent and wishes to commit suicide by taking physician-prescribed drugs.

Compassion In Dying, 850 F. Supp. at 1456-57.

The names of the patients are pseudonymous in order to protect their privacy. All three patients died after the case began. Two had died by the time the District Court issued its decision. *See Compassion In Dying v. State of Washington*, 850 F. Supp. 1454, 1456 n.2 (W.D. Wash. 1994). The other died prior to the date of the decision by the three-judge panel of this court. *Compassion In Dying v. State of Washington*, 49 F.3d 586, 588 (9th Cir. 1995).

Since the District Court properly granted the physicians standing to assert the rights of their terminally ill patients in general, 850 F. Supp. at 1467, it is clear that this case was not rendered moot by the death of the three named patients. The physicians meet both Article III and jurisprudential standing requirements. *See Singleton v. Wulff*, 428 U.S. 106, 116-17 (1976) (holding that doctors had standing to challenge — on behalf of women patients in general — a Missouri law banning Medicaid reimbursement for abortions that were not medically required). *See also Doe v. Bolton*, 410 U.S. 179, 188 (1973) (holding that physicians, asserting the rights of their patients, have standing to challenge the constitutionality of a criminal abortion statute even though "the record does

not disclose that any one of them has been prosecuted, or threatened with prosecution, for violation of the State's abortion statutes"); *Planned Parenthood of Cent. Mo. v. Danforth,* 428 U.S. 52, 62 (1976) (same). Although there is some ambiguity in *Bolton* as to whether the physicians were asserting their own rights or the rights of their patients, the Court in *Singleton*, after discussing *Griswold v. Connecticut,* 381 U.S. 479 (1965), described *Bolton* as a case "where the Court also permitted physicians to assert the rights of their patients."[3]

[1] The doctors in *Bolton* were held to have standing to assert their patients' rights even though the doctors had never been threatened with prosecution. The doctors here also meet the standing requirements because they run a severe risk of prosecution under the Washington statute, which proscribes the very conduct in which they seek to engage. The state has never indicated that it would not prosecute doctors who violate that law. *See Babbitt v. United Farm Workers National Union,* 442 U.S. 289 (1979) (holding that plaintiff does not have to risk arrest or prosecution in order to have standing to challenge the constitutionality of a criminal statute). *See also Planned Parenthood of Cent. Mo.,* 428 U.S. at 62; *Bolton*, 410 U.S. at 188 (saying that the "physician is the one against whom these criminal statutes directly operate" and that the

[3] For purposes of this appeal, we do not distinguish between the two capacities in which the doctors sue. As we explain in the text immediately following, the doctors have standing to sue on their own behalf as well as on behalf of the patients. In both cases, the doctors are required to raise the patients' liberty interests. Regardless of the capacity in which the doctors sue, the result depends on the identical constitutional inquiry: May the provision of certain medical assistance to competent, terminally ill adult patients who wish to die be prohibited by state law in light of the patients' rights and interests protected by the Due Process Clause?

"physician-appellants, therefore, assert a sufficiently direct threat of personal detriment . . . . [and] should not be required to await and undergo a criminal prosecution as the sole means of seeking relief").

We need not decide whether, the deaths of the three patient-plaintiffs would negate the ability of their lawyers to continue the challenge that those patients brought while they were still alive. *See Southern Pacific Terminal Co. v. ICC,* 219 U.S. 498, 515 (1911) (holding a case is not moot when the controversy is capable of repetition yet evading review). We note, however, that in invoking the capable-of-repetition-yet-evading-review doctrine in *Roe v. Wade,* 410 U.S. 113 (1973), the Court specifically relied, in part, on the fact that *other* women would become pregnant.[4] The Court said:

> [W]hen, as here, pregnancy is a significant fact in the litigation, the normal 266-day human gestation period is so short that the pregnancy will come to term before the usual appellate procedure is

[4] Cases after *Roe*, without mentioning *Roe*, have said that the capable-of-repetition-yet-evading-review doctrine applies when there is a reasonable expectation that the same party could be subject to the same action again. *Murphy v. Hunt,* 455 U.S. 478, 482 (1982); *Sosna v. Iowa,* 419 U.S. 393, 400-402 (1975). None of these cases, however, involved terminally ill persons. We would think that a distinction could reasonably be drawn between the terminally ill, *all* of whom *necessarily* will die prior to completion of the litigation, and those whose cases become moot for more mundane or less predictable reasons. In this connection, we note that the most common classification of terminally ill persons limits that group to individuals who are expected to die within six months. In any event we emphasize that even if the *Murphy-Sosna* interpretation of the capable-of-repetition-yet-evading-review requirement applies to cases involving terminally ill plaintiffs, this case would not be moot because the doctors have standing to challenge the Washington statute both on behalf of terminally ill patients and on their own behalf.

> complete. If that termination makes a case moot, pregnancy litigation will seldom survive much beyond the trial stage, and appellate review will be effectively denied. *Our law should not be that rigid. Pregnancy often comes more than once to the same woman, and in the general population, if man is to survive, it will always be with us.*

Roe, 410 U.S. at 125 (emphasis added). So, too, unfortunately, will terminal illness.[5]

The District Court in this case reached only claims asserted by two of the three categories of plaintiffs: the patients' claims that they had a right to receive medical assistance from their physicians and the claims that the physicians asserted on behalf of their patients. It did not address the claim asserted by Compassion In Dying. Nor, correlatively, did it reach the claim by the terminally ill patients that they had a right to receive assistance from organizations such as Compassion In Dying.

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[5] *City of Los Angeles v. Lyons*, 461 U.S. 95 (1983) is not to the contrary. In that case, Lyons claimed that Los Angeles police officers placed him in a chokehold without provocation and secured an injunction to keep LAPD officers from placing people in chokeholds except as necessary for self-defense. The Court reversed the injunction, saying that the lower court lacked jurisdiction to enter it because Lyons had not established that he was in real and immediate danger of being needlessly subjected to a chokehold again. The Court said that any future danger to Lyons was speculative because that danger would only materialize if Lyons again committed an act that caused the police to arrest him, and the police then again acted improperly or illegally. In this case, by contrast, there are unquestionably patients who are terminally ill and the danger to them and to their doctors is neither speculative nor dependent on illegal or improper actions by state actors.

Like the District Court, we decide only claims brought by the terminally ill patients and the doctors.[6] We consider those claims to the extent that they relate to the provision of certain medical assistance to terminally ill persons by physicians or persons acting pursuant to their authorization or direction. The claims involving Compassion In Dying are not before us. The district court suggested that it would reach those additional claims at a later stage in the proceedings if Compassion In Dying so desired. We have jurisdiction over this appeal from partial summary judgment because the district court certified the appeal at the request of both parties under Federal Rule of Civil Procedure 54(b).

The plaintiffs do not challenge Washington statute RCW 9A.36.060 in its entirety. Specifically they do not object to the portion of the Washington statute that makes it unlawful for a person knowingly to *cause* another to commit suicide. Rather, they only challenge the statute's "*or aids*" provision. They challenge that provision both on its face and as applied to terminally ill, mentally competent adults who wish to hasten their own deaths with the help of medication prescribed by their doctors.[7] The plaintiffs contend that the provision impermissibly prevents the exercise by terminally ill patients of a constitutionally-

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[6] While the District Court did not reach the claims that the doctors asserted on their own behalf, as we explained *supra* note 3, those claims are properly before us, and, given the result we reach, they are necessarily resolved by our decision.

[7] In their complaint, under Causes of Action, plaintiffs stated: "The Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering."

protected liberty interest in violation of the Due Process Clause of the Fourteenth Amendment, and also that it impermissibly distinguishes between similarly situated terminally ill patients in violation of the Equal Protection Clause.

In an extremely thoughtful opinion, Chief District Judge Barbara Rothstein held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide." 850 F. Supp. at 1462. Ruling on cross-motions for summary judgment, the District Court concluded that the Washington statute places an undue burden on the exercise of that constitutionally-protected liberty interest. *Id.* at 1465. The District Court held that the Washington law also violates the Equal Protection Clause because it impermissibly treats similarly situated groups of terminally ill patients differently. *Id.* at 1467. Although the scope of the relief the District Judge ordered is not clear, *id.* 1456, 1459, 1462-1464, 1467, it appears that she declared the statute invalid only insofar as it applies to the prescription of medication to terminally ill competent adults who wish to hasten their deaths — or, to use the district court's precise terminology, only insofar as it applies to "physician-assisted suicide," *id.* at 1467.[8]

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[8] Notwithstanding the District Court's declaration that the Washington statute is unconstitutional, the effect of its ruling is unclear. It is extremely unlikely that the district judge intended to strike down the entire statute, as the state asserts she did, in view of the fact that the appellants attacked only its "or aids" provision. This is particularly true because the "or aids" provision is clearly severable under Washington law. *See Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 505 (1985).

It is equally unclear whether the District Judge intended to strike the "or aids" provision on its face or as applied. *Compare Compassion In Dying*, 850 F. Supp. at 1456 *with id.* at 1459 *and id.* at 1462-64. Again, we think it unlikely that she intended to strike the entire provision for two reasons. First, the plaintiffs only argued that the assisted-suicide provision violated the constitutional rights of terminally ill, competent adults, and only offered evidence to that end. The parties did not address whether broader relief was permitted or required, and the District Court offered no explanation as to why a finding that the provision was unconstitutional as applied to the terminally ill would cause her to strike the provision on its face rather than as applied to the injured group. Second, as we noted previously, the District Court did not reach the claims raised by Compassion In Dying. *Id.* at 1467. As to Compassion In Dying, Judge Rothstein found only that summary judgment was not warranted "at this time." *Id.* at 1467-68. If the District Court had struck down the provision on its face, there would have been no purpose to its denying Compassion In Dying's summary judgment motion with a qualification that so clearly suggests that further proceedings might transpire. Nor would there have been any reason for it to have denied the doctors' motion on their own behalf in an equally non-final manner.

On appeal, a three-judge panel of this court voted 2-1 to reverse the district court decision. *Compassion In Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995). The majority held that there is no due process liberty interest in physician-assisted suicide. It also concluded that the Washington statute does not violate the Equal Protection Clause. Accordingly, the majority held that the statute is not invalid facially or as applied. Judge Wright dissented and would have held that the statute is invalid as applied to terminally ill, mentally competent adults because it violates their privacy and equal protection rights. *Id.* at 594, 597 (Wright, J., dissenting). Because of the extraordinary importance of this case, we decided to rehear it en banc. *Compassion In Dying v. State of Wash.*, 62 F.3d 299 (9th Cir. 1995).

We now affirm the District Court's decision and clarify the scope of the relief. We hold that the "or aids"

provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment.[9] Accordingly, we need not

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[9] Declaring a statute unconstitutional as applied to members of a group is atypical but not uncommon. *See, e.g., Tennessee v. Garner*, 471 U.S. 1, 11 (1985) (holding that state law permitting police officers to use deadly force to prevent the escape of felony suspects was unconstitutional as applied to suspects who pose no immediate threat to officers or others); *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (holding Wisconsin's mandatory attendance law unconstitutional but only as applied to Amish children who have graduated from eight grade). Although the Court did not explicitly use the term "as applied," it did explicitly affirm the judgment of the Wisconsin Supreme Court, *id.* at 207, which struck down the statute only as applied to Amish children who had graduated from the eighth grade. *Wisconsin v. Yoder*, 182 N.W.2d 539 (Wis. 1971).

Because we are not deciding the facial validity of RCW 9A.36.060, there can be no question that the exacting test for adjudicating claims of facial invalidity announced in *United States v. Salerno*, 481 U.S. 739 (1987), is inapplicable here. ("A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid." *Id.* at 744). For that reason alone, we would reject Washington's suggestion that we use the *Salerno* test for adjudicating plaintiffs' constitutional challenge.

Moreover, not only is there strong evidence that the Court does not generally apply the *Salerno* test, *see* Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235 (1994), but it is clear that it has applied a different test for judging the constitutionality of statutes restricting a woman's right to secure an abortion. *Planned Parenthood v. Casey*, 112 S.Ct. 2791, 2829-30 (1992). Since the claimed liberty issue in this case is in many respects similar to the liberty issue involved in *Casey*, *see* discussion *infra* at pp. 3162-3164 and 3138, we believe that the *Salerno* test would not in any event be the appropriate one for adjudicating a facial challenge to

resolve the question whether that provision, in conjunction with other Washington laws regulating the treatment of terminally ill patients,[10] also violates the Equal Protection Clause.

III.

Overview of Legal Analysis: Is There a Due Process Violation?

In order to answer the question whether the Washington statute violates the Due Process Clause insofar as it prohibits the provision of certain medical assistance to terminally ill, competent adults who wish to hasten their own deaths, we first determine whether there is a liberty interest in choosing the time and manner of one's death — a question sometimes phrased in common parlance as: Is there a right to die? Because we hold that there is, we must then determine whether prohibiting physicians from prescribing life-ending medication for use by terminally ill patients who wish to die violates the patients' due process rights. The mere recognition of a liberty interest does not mean that a state may not prohibit the exercise of that interest in particular circumstances, nor does it mean that a state may not adopt appropriate regulations governing its exercise. Rather, in cases like the one before us, the

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Washington's prohibition on assisted suicide.

[10] The Washington Natural Death Act, RCW 70.122.010 *et seq.*, states:

> adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn, in instances of a terminal condition or permanent unconscious condition . . . .

RCW 70.122.010.

courts must apply a balancing test under which we weigh the individual's liberty interests against the relevant state interests in order to determine whether the state's actions are constitutionally permissible. As Chief Justice Rehnquist, writing for the Court, explained in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the only right-to-die case that the Court has heretofore considered:

> [D]etermining that a person has a "liberty interest" under the Due Process Clause does not end our inquiry; "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Youngberg v. Romeo*, 457 U.S. 307, 321, 102 S. Ct. 2452, 2461, 73 L. Ed. 2d 28, (1982); *See also Mills v. Rogers*, 457 U.S. 291, 299, 102 S. Ct. 2442, 2448, 73 L. Ed. 2d 16 (1982).

Cruzan, 497 U.S. at 279 (footnote omitted).

The Court has invoked a balancing test in a number of substantive due process cases, not just in the right-to-die context. For example, as the *Cruzan* Court noted, the Court applied a balancing test in *Youngberg and Mills*, liberty interest cases involving the right to refuse medical treatment. *Youngberg* addressed the rights of patients involuntarily committed to state mental institutions. The Court said: "In determining whether a substantive right protected by the Due Process Clause has been violated, it is necessary to balance the liberty of the individual and the demands of organized society." *Youngberg*, 457 U.S. at 320 (internal citation and quotation omitted). *Mills* addressed the question of the right of mental patients to refuse treatment with antipsychotic drugs. There, the Court stated explicitly that the "state interests" are "to be balanced against an individual's liberty interests." 457

U.S. at 304. As the *Cruzan* Court also noted, the use of a balancing test is deeply rooted in our legal traditions. The Court has been applying a balancing test in substantive due process cases at least since 1905, when in *Jacobsen v. Massachusetts*, 197 U.S. 11 (1905), "the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease." *Cruzan*, 497 U.S. at 278.

As Justice O'Connor explained in her concurring opinion in *Cruzan*, the ultimate question is whether sufficient justification exists for the intrusion by the government into the realm of a person's "liberty, dignity, and freedom." *Cruzan*, 497 U.S. at 287, 289 (O'Connor, J., concurring). If the balance favors the state, then the given statute -- whether it regulates the exercise of a due process liberty interest or prohibits that exercise to some degree -- is constitutional. If the balance favors the individual, then the statute -- whatever its justifications -- violates the individual's due process liberty rights and must be declared unconstitutional, either on its face or as applied. Here, we conclude unhesitatingly that the balance favors the individual's liberty interest.[11]

IV.

Is There a Liberty Interest?

Before beginning our inquiry into whether a liberty interest exists, we reiterate a few fundamental precepts that guide us. The first lies in the Court's cautionary note in *Roe v. Wade*, 410 U.S. 113, 116 (1973):

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[11] For a brief discussion of the dissent's rejection by implication of the balancing test, see pp. 3139-3140 *infra*.

> We forthwith acknowledge our awareness of the sensitive and emotional nature of the . . . controversy, of the vigorous opposing views, even among physicians, and of the deep and seemingly absolute convictions that the subject inspires. One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitude toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions . . . .

Like the *Roe* Court, we endeavor to conduct an objective analysis of a most emotionally-charged of topics. In doing so, we bear in mind the second Justice Harlan's admonition in his now-vindicated dissent in *Poe v. Ullman,* 367 U.S. 497, 543 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds):

> [T]he full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere in the Constitution. This 'liberty' is not a series of isolated points pricked out in terms of the taking of property; the freedom of speech, press, and religion; the right to keep and bear arms; the freedom from unreasonable searches and seizures; and so on. It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints, . . . and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment.

Applying Justice Harlan's teaching, we must strive to resist the natural judicial impulse to limit our vision to that which

can plainly be observed on the face of the document before us, or even that which we have previously had the wisdom to recognize.

Most important, we undertake our difficult task with a profound respect for the noble objectives of the Constitution, as described by Justice Brandeis in the second most famous dissent in American jurisprudence.[12] In *Olmstead v. United States,* 277 U.S. 438 (1928), Justice Brandeis wrote, and his words have since been quoted in full in several opinions of the Court and in innumerable appellate court decisions:

> The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfaction of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone --- the most comprehensive of rights, and the right most valued by civilized men.

Id. at 478 (Brandeis, J., dissenting).

In examining whether a liberty interest exists in determining the time and manner of one's death, we begin with the compelling similarities between right-to-die cases and abortion cases. In the former as in the latter, the relative strength of the competing interests changes as physical, medical, or related circumstances vary. In right-to-die cases the outcome of the balancing test may differ at different points along the life cycle as a person's physical

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[12] The most famous dissent, of course, was that of the first Justice Harlan in *Plessy v. Ferguson,* 163 U.S. 537 (1896).

or medical condition deteriorates, just as in abortion cases the permissibility of restrictive state legislation may vary with the progression of the pregnancy.[13] Equally important, both types of cases raise issues of life and death, and both arouse similar religious and moral concerns. Both also present basic questions about an individual's right of choice.

Historical evidence shows that both abortion and assisted suicide were for many years condemned, but that the efforts to prevent people from engaging in the condemned conduct were always at most only partially successful. Even when prohibited, abortions and assisted-suicides flourished in back alleys, in small street-side clinics, and in the privacy of the bedroom. Deprived of the right to medical assistance, many pregnant women and terminally ill adults ultimately took matters into their own hands, often with tragic consequences.

Because they present issues of such profound spiritual importance and because they so deeply affect individuals' right to determine their own destiny, the abortion and right-to-die cases have given rise to a highly emotional and divisive debate. In many respects, the legal arguments on

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[13] Most of the liberty interests or rights that the Court recognized before *Roe* are static. One's liberty interest in marriage, procreation, family relationships, child rearing, intercourse for purposes other than procreation, and whether or not to bear or beget children, for instance, remains relatively constant, at least throughout one's adult years. Similarly the state's countervailing interests change little if at all. Abortion cases require a more dynamic mode of analysis, however. In *Roe*, the Court explained that the relative weight of a woman's liberty interest in terminating an unwanted pregnancy, compared to the state's interest in protecting life shifts dramatically during the course of a pregnancy. As a result, the extent to which state action is permissible shifts dramatically as well. *See also Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992).

both sides are similar, as are the constitutional principles at issue.

In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. *Casey* in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment. Although *Casey* was influenced by the doctrine of *stare decisis*, the fundamental message of that case lies in its statements regarding the type of issue that confronts us here: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Casey*, 112 S. Ct. at 2807.

A.

Defining the Liberty Interest and Other Relevant Terms

The majority opinion of the three-judge panel that first heard this case on appeal defined the claimed liberty interest as a "constitutional right to *aid* in killing oneself." *Compassion In Dying*, 49 F.3d at 591 (emphasis added). However, the subject we must initially examine is not nearly so limited. Properly analyzed, the first issue to be resolved is whether there is a liberty interest in determining the time and manner of one's death. We do not ask simply whether there is a liberty interest in receiving "aid in killing oneself" because such a narrow interest could not exist in the absence of a broader and more important underlying interest -— the right to die. In short, it is the end and not the means that defines the liberty interest.

The broader approach we employ in defining the liberty interest is identical to the approach used by the Supreme Court in the abortion cases. In those cases, the Court initially determined whether a general liberty interest

existed (an interest in having an abortion), not whether there was an interest in implementing that general liberty interest by a particular means (with medical assistance). Specifically, in *Roe v. Wade*, 410 U.S. 113 (1973), the Court determined that women had a liberty interest in securing an abortion, not that women had a liberty interest in obtaining medical assistance for purpose of an abortion. The Court did so even though the Texas statute at issue did not prohibit a woman from inducing her own abortion; nor did it criminalize a woman's conduct in securing an abortion. Rather, the Texas statute, like the Washington statute here, prohibited the rendering of assistance; specifically, the Texas statute prohibited only *assisting* a woman to secure an abortion. *Roe*, 410 U.S. at 151-52. The Court first determined that a woman had a constitutional right to choose an abortion. Only after it did so, did it proceed to the second step: to determine whether the state's prohibition on assistance unconstitutionally restricted the exercise of that liberty interest. Similarly, in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), the Court first reaffirmed, after extensive analysis, its earlier holding that women have a liberty interest in obtaining an abortion. In determining the *existence* of that liberty interest, the Court did not address the subject of spousal notification. As in *Roe*, only after affirming a woman's right to have an abortion, did the Court proceed to the second step: to examine whether the statutory provision requiring married women to notify their spouses prior to obtaining an abortion posed an undue burden on the exercise of that liberty interest. In this case, our analysis is necessarily the same. First we must determine whether there *is* a liberty interest in determining the time and manner of one's death; if so, we must then examine whether Washington's ban on assisted suicide unconstitutionally restricts the exercise of that liberty interest.

While some people refer to the liberty interest implicated in right-to-die cases as a liberty interest in committing suicide, we do not describe it that way. We use the broader and more accurate terms, "the right to die," "determining the time and manner of one's death," and "hastening one's death" for an important reason. The liberty interest we examine encompasses a whole range of acts that are generally not considered to constitute "suicide." Included within the liberty interest we examine, is for example, the act of refusing or terminating unwanted medical treatment. As we discuss later at pp. 3179- 3180, a competent adult has a liberty interest in refusing to be connected to a respirator or in being disconnected from one, even if he is terminally ill and cannot live without mechanical assistance. The law does not classify the death of a patient that results from the granting of his wish to decline or discontinue treatment as "suicide." Nor does the law label the acts of those who help the patient carry out that wish, whether by physically disconnecting the respirator or by removing an intravenous tube, as assistance in suicide. Accordingly, we believe that the broader terms -— "the right to die," "controlling the time and manner of one's death," and "hastening one's death" -— more accurately describe the liberty interest at issue here. Moreover, as we discuss later, we have serious doubts that the terms "suicide" and "assisted suicide" are appropriate legal descriptions of the specific conduct at issue here. *See infra* 3185-3186.

There is one further definitional matter we should emphasize. Following our determination regarding the existence of a liberty interest in hastening one's death, we examine whether the Washington statute unconstitutionally infringes on that liberty interest. Throughout that examination, we use the term "physician-assisted suicide," a term that does not appear in the Washington statute but

is frequently employed in legal and medical discussions involving the type of question before us. For purposes of this opinion, we use physician-assisted suicide as it is used by the parties and district court and as it is most frequently used: the prescribing of medication by a physician for the purpose of enabling a patient to end his life.[14] It is only that conduct that the plaintiffs urge be held constitutionally-protected in this case.[15]

B.

The Legal Standard

There is no litmus test for courts to apply when deciding whether or not a liberty interest exists under the Due Process Clause. Our decisions involve difficult judgments regarding the conscience, traditions, and fundamental tenets of our nation. We must sometimes apply those basic principles in light of changing values based on shared experience. Other times we must apply them to new problems arising out of the development and use of new technologies. In all cases, our analysis of the applicability of the protections of the Constitution must be made in light

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[14] *See, e.g.*, Sarah Henry, The Battle Over Assisted-Suicide, Calif. Law., 1, 35 (defining physician-assisted death "as providing or prescribing medication to someone, knowing that that person intends to take a lethal dose of the medication").

[15] We use the terms "assisted suicide" and "physician-assisted suicide" interchangeably throughout this opinion, although as we have noted, we have serious doubts as to the correctness or propriety of the terms, as they are generally used. We should note, however, that there is another commonly used term -- "physician-aid-in-dying" -- that is also relevant to our discussion. That term includes not only the prescribing of drugs ("assisted suicide") but also the *administration* of drugs by the physician. The issue of the constitutionality of prohibiting physicians from administering life-ending drugs to terminally ill persons is not before us for decision.

of existing circumstances as well as our historic traditions. Historically, the Court has classified "fundamental rights" as those that are "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). The Court reasserted this historic standard, along with an alternative description, in its highly controversial *Bowers v. Hardwick* opinion, 478 U.S. 186, 191-92 (1986):[16]

> Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection. In *Palko v. Connecticut*, 302 U.S. 319, 325, 326, 82 L. Ed. 288, 58 S. Ct. 149 (1937), it was said that this category includes those fundamental liberties that are

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[16] The case was decided by a 5-4 vote, and Justice Powell subsequently announced on several occasions that he regretted that vote. "I think I probably made a mistake," Powell reportedly once said. Upon rereading the opinion a few months after it was issued, he reportedly remarked, "I thought the dissent had the better of the argument." David Cole, *Playing Pornography's Rule: The Regulation of Sexual Expression*, 143 U. Pa. L. Rev. 111, 176-77 (1994), *citing* Linda Greenhouse, When Second Thoughts in a Case Come Too Late, N.Y. Times, Nov. 5, 1990, at 14. The *Bowers* decision has been widely criticized by commentators. William N. Eskridge Jr. and Phillip P. Frickey, *The Supreme Court 1993 -- Forward: Law as Equilibrium*, 108 Harv. L. Rev. 26, 95 (1994) (criticizing *Bowers* for embodying "segregationist" caste distinctions similar to those upheld in *Plessy v. Ferguson*); Kendall Thomas, *The Eclipse of Reason: A Rhetorical Reading of Bowers v. Hardwick*, 79 Va. L. Rev. 1805, 1806 (1993) (saying *Bowers* represents a homophobic ideology); Lance Liebman, *A Tribute to Justice Byron A. White*, 107 Harv. L. Rev. 13, 19 (1993) (calling *Bowers* Justice White's worst opinion). The passage quoted in the text, however, is not controversial.

"implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland*, 431 U.S. 494, 503, 97 S. Ct. 1932, 1937, 52 L Ed. 2d 531 (1977) (opinion of POWELL, J.), where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition." *Id.* at 503, 97 S. Ct. at 1938 (POWELL, J.).

In recent years, the Court has spoken more frequently of substantive due process *interests* than of *fundamental* due process *rights*. *Compare Thornburgh v. American Coll. of Obst.*, 476 U.S. 747, 772 (1986) (describing "fundamental right" to abortion) and *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 420 n.1 (1983) (same) *with Webster v. Reproductive Health Services*, 492 U.S. 490, 520 (1989) (plurality opinion) (describing women's entitlement to an abortion as a "liberty interest protected by Due Process Clause"). *See also Cruzan*, 497 U.S. 2841. The Court has also recently expressed a strong reluctance to find new fundamental rights. *Collins v. City of Harker Heights*, Tex., 112 S. Ct. 1061, 1068 (1992).

The Court's evolving doctrinal approach to substantive due process claims is consistent with the basic truth enunciated by Justice Harlan and later endorsed by the Court in *Casey*: "the full scope of the liberty guaranteed by the Due Process Clause is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . ." *Casey*, 112 S. Ct. at 2806, citing *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting from dismissal on

jurisdictional grounds).[17] As Justice Harlan noted, some liberty interests are weightier than others. Under the Court's traditional jurisprudence, those classified as fundamental rights cannot be limited except to further a compelling and narrowly tailored state interest. *See Collins*, 112 S. Ct. at 1068. Other important interests, such as the liberty interest in refusing unwanted medical treatment, are subject to a balancing test that is less restrictive, but nonetheless requires the state to overcome a substantial hurdle in justifying any significant impairment.

Recent cases, including *Cruzan*, suggest that the Court may be heading towards the formal adoption of the continuum approach, along with a balancing test, in substantive due process cases generally. If so, there would no longer be a two-tier or three-tier set of tests that depends on the classification of the right or interest as fundamental, important, or marginal. Instead, the more important the individual's right or interest, the more persuasive the justifications for infringement would have to be. We see the evolution in the Court's approach more as a recognition of the artificiality of the current classification system than as a fundamental change in the Court's practical approach to specific issues. So long as the liberty interest is an important one, the state must shoulder the burden of justifying any significant limitations it seeks to impose. However, we need not predict the Court's future

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[17] This passage appears in Part II of the joint opinion by Justices O'Connor, Kennedy, and Souter. In their concurring opinions, both Justice Stevens and Justice Blackmun joined in that part of the joint opinion. 112 S. Ct. at 2843. Thus Part II represents the views of five justices and so the Court. Unless otherwise noted, all passages cited from *Casey* represent the opinion of the Court and not merely a plurality of its members.

course in order to decide the case before us. Here, as we have said, even under the Court's traditional mode of analysis, a balancing test is applicable.

Nothing in *Reno v. Flores*, 113 S. Ct. 1439 (1993), the insubstantial reed on which the dissent rests its case — even though the case was not cited by any of the parties or any of the eleven amici who filed briefs before this court — suggests anything to the contrary. In *Flores*, the Court simply declined to find a new fundamental right, and repeated its general reluctance to do so. *Id.* at 1447. The Court did not, as the dissent implies, purport to establish a new classification system under which all liberty interests other than fundamental rights would be subject to rational basis review. Nor did *Flores* purport to overrule, or even hint at any desire to modify, the Court's ninety-year-old practice of using a balancing test in liberty interest cases that raise important issues of the type before us. In fact, *Flores* did not mention *Cruzan*, *Youngberg*, *Mills*, *Jacobsen*, or any other balancing case.[18] While one might legitimately argue either that the liberty interest at issue here rises to the level of a fundamental right or that it is simply an important liberty interest that is subject to a balancing test, one point is absolutely clear: there can be no legitimate argument that rational basis review is applicable, and *nothing* in *Flores* suggests that it is.

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[18] In one case in which the liberty interest was at a bare minimum because it involved the interest of uniformed police officers in their *appearance* -- a matter in which the Court said that the citizenry at large had only *"some sort* of liberty interest" and suggested that uniformed police officers had far less even than that -- the Court subjected departmental grooming regulations to rational basis review. *See Kelley v. Johnson*, 425 U.S. 238, 244, 248-249 (1976). Subsequent to that decision, however, with liberty interests of more than minimal weight, the Court has consistently applied either strict scrutiny or a balancing test.

Although in determining the existence of important rights or liberty interests, the Court examines our history and experience, it has stated on a number of occasions that the limits of the substantive reach of the Due Process Clause are not frozen at any point in time. In *Casey*, the Court said: "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." 112 S. Ct. at 2805. Justice Frankfurter may have put it best when, writing for the Court in *Rochin v. California*, 342 U.S. 165, 171-72 (1952), he declared, "To believe that this judicial exercise of judgment could be avoided by freezing 'due process of law' at some fixed stage in time or thought is to suggest that the most important aspect of constitutional adjudication is a function for inanimate machines and not for judges . . . ." Certainly, it would be difficult to imagine a more felicitous expression of the dynamism of constitutional interpretation. Thus, while historical analysis plays a useful role in any attempt to determine whether a claimed right or liberty interest exists, earlier legislative or judicial recognition of the right or interest is not a *sine qua non*.

In *Casey*, the Court made it clear that the fact that we have previously failed to acknowledge the existence of a particular liberty interest or even that we have previously prohibited its exercise is no barrier to recognizing its existence. In discussing a woman's liberty interest in securing an abortion, the *Casey* Court stated that pregnancy involves "suffering [that] is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, *however dominant that vision has been in the course of our history and culture*." *Casey*, 112 S. Ct. at 2807 (emphasis added).

[2] In contrast to *Casey*, the majority opinion of the three judge panel in the case now before us erroneously concluded that a historical analysis alone is sufficient basis for rejecting plaintiffs' claim to a substantive liberty interest or right. *Compassion In Dying*, 49 F.3d at 591. As explained below, we believe that the panel's historical account is misguided, but even if it were indisputably correct, historical evidence alone is not a sufficient basis for rejecting a claimed liberty interest.[19]

Were history our sole guide, the Virginia anti-miscegenation statute that the Court unanimously overturned in *Loving v. Virginia*, 388 U.S. 1 (1967), as violative of substantive due process and the Equal Protection Clause, would still be in force because such anti-miscegenation laws were commonplace both when the United States was founded and when the Fourteenth Amendment was adopted.[20] The Court explicitly

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[19] The district judge who heard the constitutional challenge to the New York Statute barring doctors from helping terminally ill, competent adults to hasten their deaths committed a similar error in concluding that plaintiffs' alleged failure to offer historical evidence was fatal to their claim. *Quill v. Koppell*, 870 F. Supp. 78, 83 (S.D.N.Y. 1994) ("The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right.").

[20] Had the Court applied a rigid, originalist view of constitutional interpretation, a married couple consisting of a black husband and a white wife (or vice-versa) would be unable to live in the state of Virginia today. Our nation's long history of outlawing racially-mixed marriages is traceable to the early colonial period. The first anti-miscegenation statute was passed in Maryland in 1661. Harvey M. Applebaum, *Miscegenation Statutes: A Constitutional and Social Problem*, 53 Geo. L.J. 49, 50 (1964).

As the nation grew, so did the number of states with miscegenation bans. Forty-one states enacted anti-miscegenation statutes at one time

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or another; all but three of these forty-one states had such statutes during the nineteenth century. Applebaum, *supra*, at 50 & n.9. During the time surrounding the Congressional debates concerning the passage of the Fourteenth Amendment, all the slave states and most of the non-slave states had anti-miscegenation statutes. R. Carter Pittman, *The Fourteenth Amendment: Its Intended Effect on Anti-Miscegenation Laws*, 43 N.C. L. Rev. 92, 106 (1964).

The passage of the Fourteenth Amendment had little effect on the judiciary's view of the constitutionality of anti-miscegenation statutes. Even as late as the early 1960's, only a few years before the *Loving* decision, the courts continued to hold to the strong tradition prohibiting interracial marriages:

> The courts of last resort of fifteen states have reached the question of their [anti-miscegenation statutes'] constitutionality and all but one have upheld them. In addition, the federal [district] courts and the one federal court of appeals that have been confronted with the statutes have sustained their constitutional validity.

Applebaum, *supra*, at 56 (footnotes omitted). *See also* James Trosino, *American Wedding: Same-Sex Marriage and the Miscegenation Analogy*, 73 B.U. L. Rev. 93, 104 (1993) ("In the 100 years following the ratification of the Fourteenth Amendment, only one state court overturned an anti-miscegenation law.").

The Supreme Court did not directly address the constitutionality of proscriptions against interracial marriage until its decision in *Loving*. It could have done so previously but chose to sidestep the issue. *See Pace v. Alabama*, 106 U.S. 583, 585 (1883). At the time of the *Loving* decision, sixteen states still prohibited and punished interracial marriages. *Loving*, 388 U.S. at 6. Six of those states went so far as to include in their state constitutions a provision banning interracial marriages. 388 U.S. at 6 n.5.

The *Loving* Court declared anti-miscegenation statutes unconstitutional, saying that they violated both the Equal Protection Clause and the Due Process Clause. In so doing, the Court rejected three hundred years of tradition and overwhelming precedent to the contrary.

acknowledged as much in *Casey*, 112 S. Ct. at 2805, in rejecting the view that substantive due process protects rights or liberties only if they possess a historical pedigree. In *Casey*, the Court said:

> It is . . . tempting . . . to suppose that the Due Process Clause protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified. . . . But such a view would be inconsistent with our law. It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. We have vindicated this principle before. Marriage is mentioned nowhere in the Bill of Rights and interracial marriage was illegal in most States in the 19th century, but the Court was no doubt correct in finding it to be an aspect of liberty protected against state interference by the substantive component of the Due Process Clause in *Loving v. Virginia*, 388 U.S. 1, 12, 87 S. Ct. 1817, 1824, 18 L. Ed. 2d 1010 (1967), (relying, in an opinion for eight Justices, on the Due Process Clause). Similar examples may be found in *Turner v. Safley*, 482 U.S. 78, 94-99, 107 S. Ct. 2254, 2265-67, 96 L. Ed. 2d 64 (1987) [holding that prisoners have a constitutionally protected right to marry a civilian or other inmate]; in *Carey v. Population Services International*, 431 U.S. 678, 684, 686, 97 S. Ct. 2010, 2015-2017, 52 L. Ed. 2d 675 (1977) [holding that the state cannot prohibit the sale of contraceptives to all minors or bar everyone but licensed pharmacists from selling contraceptives to adults]; in *Griswold v. Connecticut*, 381 U.S. 479, 481-82, 85 S. Ct. 1678, 1680-81, 14 L. Ed. 2d 510 (1965)

> [holding that a Connecticut law forbidding the use of contraceptives unconstitutionally intrudes on the right of marital privacy] . . .

Casey, 112 S. Ct. at 2805. Indeed, if historical evidence of accepted practices at the time the Fourteenth Amendment was enacted were dispositive, the Court would not only have decided *Loving* differently, but it would not have held that women have a right to have an abortion. As the dissent pointed out in *Roe*, more than three-quarters of the existing states (at least 28 out of 37 states), as well as eight territorial legislatures restricted or prohibited abortions in 1868 when the Fourteenth Amendment was adopted. *Roe*, 410 U.S. at 175-76 & n.1 (Rehnquist, J., dissenting).

C.

Historical Attitudes Toward Suicide

The majority opinion of the three-judge panel claimed that "a constitutional right to aid in killing oneself " was "unknown to the past." *Compassion In Dying*, 49 F.3d at 591. As we have pointed out at p. 3138, our inquiry is not so narrow. Nor is our conclusion so facile. The relevant historical record is far more checkered than the majority would have us believe.

Like the Court in *Roe*, we begin with ancient attitudes.[21] In Greek and Roman times, far from being

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[21] When the Court turns to history, it does not limit its inquiry to the practices at the time of the founding or the time of the adoption of the Fourteenth Amendment. Rather, the Court also looks to British common law and beyond. In *Roe*, for example, Justice Blackmun, writing for the majority, went to great pains to show that abortion was practiced "in Greek times and in the Roman era" and also that abortion of a fetus before quickening was not a crime at English common law or in the early days of the American Republic. *Roe*, 410 U.S. at 130-140.

universally prohibited, suicide was often considered commendable in literature, mythology, and practice.

> The first of all literary suicides, that of Oedipus' mother, Jocasta, is made to seem praiseworthy, an honorable way out of an insufferable situation. Homer records self-murder without comment, as something natural and heroic. The legends bear him out. Aegeus threw himself into the sea — which therefore bore his name -— when he mistakenly thought his son Theseus had been slain by the Minotaur.

A. Alvarez, *The Background, in Suicide: The Philosophical Issues* 18 (M.Pabst Battin and David J. Mayor, eds. 1980). In Athens, as well as the Greek colonies of Marseilles and Ceos, magistrates kept a supply of hemlock for those who wished to end their lives. The magistrates even supplied those who wished to commit suicide with the means to do so.

> Whoever no longer wishes to live shall state his reasons to the Senate, and after having received permission shall abandon life. If your existence is hateful to you, die; if you are overwhelmed by fate, drink the hemlock. If you are bowed with grief, abandon life. Let the unhappy man recount his misfortune, let the magistrate supply him with the remedy, and his wretchedness will come to an end.[22]

While Socrates counseled his disciples against committing suicide, he willingly drank the hemlock as he was condemned to do, and his example inspired others to end

[22] Emile Durkheim, *Suicide: A Study in Sociology* 330 (John A. Spaulding & George Simpson trans., 1951) (citing Libanius).

their lives. *Id.* at 19. Plato, Socrates' most distinguished student, believed suicide was often justifiable.

> He suggested that if life itself became immoderate, then suicide became a rational, justifiable act. Painful disease, or intolerable constraint were sufficient reasons to depart. And this when religious superstitions faded was philosophic justification enough. *Id.*

Many contemporaries of Plato were even more inclined to find suicide a legitimate and acceptable act. In *Roe*, while surveying the attitudes of the Greeks toward abortion, the Court stated that "only the Pythagorean school of philosophers frowned on the related act of suicide," 410 U.S. at 131; it then noted that the Pythagorean school represented a distinctly minority view. *Id.*

The Stoics glorified suicide as an act of pure rational will.[23] Cato, who killed himself to avoid dishonor when Ceasar crushed his military aspirations, was the most celebrated of the many suicides among the Stoics. Montaigne wrote of Cato: "This was a man chosen by nature to show the heights which can be attained by human steadfastness and constancy . . . . Such courage is above philosophy."

Like the Greeks, the Romans often considered suicide to be acceptable or even laudable.[24]

[23] Thomas J. Marzen, et al., *Suicide: A Constitutional Right*, 24 Duq. L. Rev. 1, 25 (1985) [hereinafter Marzen].

[24] Other ancient peoples also viewed suicide with equanimity or acceptance. Hundreds of Jews killed themselves at Masada in order to avoid being captured by Roman legions. The ancient Sythians believed it was an honor to commit suicide when they became too frail for their nomadic way of life. The Vikings believed that the next greatest honor, after death in battle, was death by suicide. *Id.* at 14-17.

To live nobly also meant to die nobly and at the right time. Everything depended on a dominant will and a rational choice.

This attitude was reinforced by Roman law. . . . According to Justinian's *Digest*, suicide of a private citizen was not punishable if it was caused by "impatience of pain or sickness, or by another cause," or by "weariness of life . . . lunacy, or fear of dishonor." Since this covered every rational cause, all that was left was the utterly irrational suicide "without cause," and that was punishable on the grounds that "whoever does not spare himself would much less spare another." In other words, it was punished because irrational, not because it was a crime. *Id.* at 22-23.

The Romans did sometimes punish suicide. Under Roman law, people convicted of crimes forfeited their property to the Emperor, thereby disinheriting their heirs. Roman law imposed a special penalty on people who were caught committing a crime and then committed suicide prior to conviction to avoid forfeiting the property. To protect the Emperor's interests, the property of people who committed suicide under such circumstances was forfeited, just as if they had been convicted of the crime involved. Marzen at 57-58.

The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven.[25] "In other words, the more powerfully the Church instilled in believers the idea that this world was a

[25] The stories of four suicides are noted in the Old Testament -- Samson, Saul, Abimlech, and Achitophel -- and none is treated as an act worthy of censure. In the New Testament, the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance.

vale of tears and sin and temptation, where they waited uneasily until death released them into eternal glory, the more irresistible the temptation to suicide became." *Id.* at 25. The Christian impulse to martyrdom reached its height with the Donatists, who were so eager to enter into martyrdom that they were eventually declared heretics. Gibbon, in the Decline and Fall of the Roman Empire, described them this way:

> They sometimes forced their way into courts of justice and compelled the affrighted judge to give orders for their execution. They frequently stopped travellers on the public highways and obliged them to inflict the stroke of martyrdom by promise of a reward, if they consented -— and by the threat of instant death, if they refused to grant so singular a favour.[26]

St. Augustine said of the Donatists, "to kill themselves out of respect for martyrdom is their daily sport." *Id.* at 27. Prompted in large part by the utilitarian concern that the rage for suicide would deplete the ranks of Christians, St. Augustine argued that committing suicide was a "detestable and damnable wickedness" and was able to help turn the tide of public opinion. *Id.* Even staunch opponents of a constitutional right to suicide acknowledge that "there were many examples of Christian martyrs whose deaths bordered on suicide, and confusion regarding the distinction between suicide and martyrdom existed up until the time of St. Augustine (354-430 A.D.)."[27]

In 562 A.D., the Council of Braga denied funeral rites to anyone who killed himself. A little more than a century

[26] Edward Gibbon, I *Decline and Fall of the Roman Empire* 721 (Oliphant Smeaton ed.).

[27] Marzen, *supra* note 23, at 26.

later, in 693 A.D., the Council of Toledo declared that anyone who attempted suicide should be excommunicated. *Id.* at 27-28. Once established, the Christian view that suicide was in all cases a sin and crime held sway for 1,000 years until philosophers, poets, and even some clergymen -— Montesquieu, Voltaire, Diderot, Francis Bacon, David Hume, John Donne, Sir Thomas More, among others[28] —- began to challenge the all-encompassing nature of the dominant ideology. In his book Utopia, Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of the terminally ill to commit suicide and also expressed approval of the practice of assisting those who wished to hasten their deaths.[29] Hume argued that a decision by a terminally ill patient to end his life was often laudable.[30] France even enacted a statute legalizing suicide in 1790, primarily as a result of the influence of the nation's leading philosophers.[31]

Suicide was a crime under the English common law, at least in limited circumstances, probably as early as the

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[28] Thane Josef Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 Denv. U. L. Rev. 175, 185-188 (1993).

[29] *Id.* at 185, *citing* St. Thomas More, Utopia 55-56 (Edward Surtz ed., 1964).

[30] *Id. citing* David Hume, Dialogues Concerning Natural Religion and the Posthumous Essays of the Immortality of the Soul and of Suicide 103-104 (Richard H. Popkin ed., 1980); Tom L. Beauchamp, Suicide in the Age of Reason 184 in Suicide and Euthanasia: Historical and Contemporary Themes (Barough A. Brody ed., 1989).

[31] Messinger, *supra* note 28, at 188.

thirteenth century.[32] Bracton, incorporating Roman Law as set forth in Justinian's *Digest*, declared that if someone commits suicide to avoid conviction of a felony, his property escheats to his lords.[33] Bracton said"[i]t ought to be otherwise if he kills himself through madness or unwillingness to endure suffering."[34] Despite his general fidelity to Roman law, Bracton did introduce a key innovation: "[I]f a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . he may have a successor, but his movable goods [personal property] are confiscated. He does not lose his inheritance [real property], only his movable goods."[35] Bracton's innovation was incorporated into English common law, which has thus treated suicides resulting from the inability to "endure further bodily pain" with compassion and understanding ever since a common law scheme was firmly established.

Sir Edward Coke, in his *Third Institute* published in 1644, held that killing oneself was an offense and that someone who committed suicide should forfeit his movable property. But Coke listed an exception for someone who "by the rage of sickness or infirmity or otherwise," kills himself "while he is not of compos mentia," or sound mind.[36] In eighteenth century England, many and perhaps most juries compensated for the perceived unfairness of the law by concluding that anyone who killed himself was

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[32] 2 H. de Bracton (c. 1250) *reprinted in On the Laws and Customs of England* 423 (S. Thorne trans., 1968).

[33] Marzen, *supra* note 23, at 58-59.

[34] *Id.*

[35] *Id.*

[36] *Id.* at 61.

necessarily *not* of sound mind.[37] Thus, although, formally, suicide was long considered a crime under English common law, in practice it was a crime that was punished leniently, if at all, because juries frequently used their power to nullify the law.

The traditional English experience was also shaped by the taboos that have long colored our views of suicide and perhaps still do today. English common law reflected the ancient fear that the spirit of someone who ended his own life would return to haunt the living. Accordingly, the traditional practice was to bury the body at a crossroads — either so the suicide could not find his way home or so that the frequency of travelers would keep his spirit from rising.[38] As added insurance, a stake was driven through the body.

English attitudes toward suicide, including the tradition of ignominious burial, carried over to America[39] where they subsequently underwent a transformation. By 1798, six of the 13 original colonies had abolished all penalties for suicide either by statute or state constitution.[40] There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-

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[37] *Id.*

[38] 4 William Blackstone, *Commentaries* 190 (noting that people who committed suicide were subject to "an ignominious burial in the highway, with a stake driven through the body").

[39] This practice was continued in seventeenth century Virginia. In 1661, for instance, a jury found a man guilty of suicide and "caused him to be buried at the next cross path as the Law Requires with a stake driven though the middle of him in his grave." Marzen, *supra* note 23, at 64-65, *citing* A. Scott, *Criminal Law in Colonial Virginia* at 198-199 & n.16 (1930).

[40] Marzen, *supra* note 23, at 67.

revolutionary America.[41] By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the 37 states is it clear that there were statutes prohibiting assisting suicide.[42]

The majority of states have not criminalized suicide or attempted suicide since the turn of the century.[43] The New Jersey Supreme Court declared in 1901 that since suicide was not punishable it should not be considered a crime. "[A]ll will admit that in some cases it is ethically defensible," the court said, as when a woman kills herself to escape being raped or "when a man curtails weeks or months of agony of an incurable disease." *Campbell v. Supreme Conclave Improved Order Heptasophs*, 66 N.J.L. 274, 49 A. 550, 553 (1901).[44] Today, no state has a statute prohibiting suicide or attempted suicide; nor has any state had such a statute for at least 10 years.[45] A majority of states do, however, still have laws on the books against assisting suicide.[46]

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[41] Catherine D. Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 Colum. L. Rev. 348, 350 (1986).

[42] Marzen, *supra* note 23, at 75. Nevertheless, extrapolating from incomplete historical evidence and drawing inferences from states' treatment of suicide and from later historical evidence, Marzen hypothesized that in 1868, "twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide." *Id.* at 76.

[43] Marzen, *supra* note 23, at 85.

[44] Cited by Marzen, *supra* note 23, at 84.

[45] *Id.* at 350 (noting in 1986 that no state prohibits suicide or attempted suicide by statute).

[46] Julia Pugliese, Note, *Don't Ask -- Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1291, 1295 (1993).

D.

Current Societal Attitudes

[3] Clearly the absence of a criminal sanction alone does not show societal approbation of a practice. Nor is there any evidence that Americans approve of suicide in general. In recent years, however, there has been increasingly widespread support for allowing the terminally ill to hasten their deaths and avoid painful, undignified, and inhumane endings to their lives. Most Americans simply do not appear to view such acts as constituting suicide, and there is much support in reason for that conclusion. *See infra* at pp. 3185-3186.

Polls have repeatedly shown that a large majority of Americans — sometimes nearing 90% — fully endorse recent legal changes granting terminally ill patients, and sometimes their families, the prerogative to accelerate their death by refusing or terminating treatment.[47] Other polls indicate that a majority of Americans favor doctor-assisted suicide for the terminally ill. In April, 1990, the Roper Report found that 64% of Americans believed that the terminally ill should have the right to request and receive physician aid-in-dying.[48] Another national poll, conducted in October 1991, shows that "nearly two out of three Americans favor doctor-assisted suicide and euthanasia for terminally ill patients who request it."[49] A 1994 Harris

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[47] Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Cal. L. Rev. 857, 860 & n.16 (citing sources).

[48] Robert Risley, *Voluntary Active Euthanasia: the Next Frontier, Impact on the Indigent*, 8 Issues In Law & Med. 361, 365 (1992).

[49] Kadish, *supra* note 47,at 861 n. 22, *citing* Euthanasia Favored in Poll, N.Y. Times, Nov. 4, 1991, at A16.

poll found 73% of Americans favor legalizing physician-assisted suicide.[50] Three states have held referenda on proposals to allow physicians to help terminally ill, competent adults commit suicide with somewhat mixed results. In Oregon, voters approved the carefully-crafted referendum by a margin of 51 to 49 percent in November of 1994.[51] In Washington and California where the measures contained far fewer practical safeguards, they narrowly failed to pass, each drawing 46 percent of the vote.[52] As such referenda indicate, there is unquestion-ably growing popular support for permitting doctors to provide assistance to terminally ill patients who wish to hasten their deaths.[53]

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[50] David Cannella, Physician-Assisted Suicide, Fight Rages in Several States: Issue Expected to Go to the Supreme Court, The Arizona Republic, May 13, 1995. A Field poll conducted in California in March 1995 found that 70% of Californians agreed that the terminally ill should be able to obtain medication from their doctors to end their lives. Henry, *supra* note 14, at 35.

[51] The Oregon statute was enjoined by a federal district judge the day before it was to take effect. *See Lee v. State of Oregon*, 891 F. Supp. 1429 (D. Or. 1995), discussed *infra* at pp. 106-107.

[52] Cheryl K. Smith, *What About Legalized Assisted Suicide*, 8 Issues In Law & Med. 503, 503 (1993). Proposals to permit physician-assisted suicide have also been introduced in Iowa, Maine, Michigan, and New Hampshire. *Id.* at 503 nn. 3-6.

[53] See *Shaffer*, *supra* note 41, at 367 n.114, stating:

> The National Opinion Research Group asked in a survey: "'When a person has a disease that cannot be cured, do you think that doctors should be allowed by law to end the patient's suffering by some painless means if the patient and his family request it.' " N.Y. Times, Sept. 23, 1984, S 1, at 1, col. 3. In 1947, 37% of the respondents said "yes." In 1973, a little over half agreed, and in 1983, 63% replied affirmatively. *Id.*

Just as the mere absence of criminal statutes prohibiting suicide or attempted suicide does not indicate societal approval so the mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death.[54] The lack of enforcement of statutes prohibiting assisting a mentally competent, terminally ill adult to end his own life would appear to reflect widespread societal disaffection with such laws.[55]

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[54] Franklin G. Miller et al, *Regulating Physician-Assisted Death*, 331 N. Eng. J. Med. 119, 119 (1994). Dr. Jack Kevorkian is currently facing criminal charges for helping several patients hasten their deaths. His case presents a number of peculiar factors that prevent us from drawing any particular inferences from the fact that local authorities in Michigan have made a number of efforts to obtain a conviction.

In a celebrated, though less complicated, recent example, a grand jury decided against indicting Dr. Timothy Quill, who admitted in the pages of the *New England Journal of Medicine* that he had intentionally prescribed the barbiturates that a terminally ill patient used to end her life. Pugliese, *supra* note 46, at 1298 n. 47.

Quill's case was not exceptional. In 1973, a New York physician who administered a lethal injection to a comatose patient was acquitted of assisted suicide. In 1950, another doctor was acquitted after injecting a "fatal air embolism into the blood vessels of a carcinoma patient, who had repeatedly urged him to end her misery." *Id.* at 1298 nn. 45-46.

[55] *See* Kadish, *supra* note 47, at 859 & n.10, noting that no-fault divorce "came well after the widespread nullification of strict divorce requirements" and also that "the legitimation of plea bargaining followed . . . decades of its widespread but officially denied practice."

Our attitudes toward suicide of the type at issue in this case are better understood in light of our unwritten history and of technological developments. Running beneath the official history of legal condemnation of physician-assisted suicide is a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths.[56] According to a survey by the American Society of Internal Medicine, one doctor in five said he had assisted in a patient's suicide.[57] Accounts of

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[56] *See generally* Pugliese, *supra* note 46. Some experts estimate that notwithstanding criminal sanctions, physicians may play a role in hastening the deaths of 6,000 terminally ill patients a day, many through the use of pain relieving drugs that accelerate death. Timothy E. Quill, et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med., 1380, 1381 (1992).

[57] Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2021 n.7 (1992) (citing Richard A. Knox, One in Five Doctors Say They Assisted in a Patient's Death, Survey Finds, Boston Globe, Feb. 28, 1992 at 5). According to the same survey, one doctor in four said he had been asked by a patient for assistance in ending his life. *See also* Lawrence K. Altman, More Physicians Broach Forbidden Subject of Euthanasia, N.Y. Times, Mar. 12, 1991, at C3.

Another poll of physicians showed that 10% of the respondents admitted to assisting a patient to end his life in some way. Doctors Who Help Patients Die; MD's Reveal a Secret Practice: Aiding Suicides, Mercy Killing, Newsday, Sept. 29, 1991 at 4 (reporting that 10% of respondents to poll by Physician's Management Magazine admitted to assisting suicide in some way).

The figures are considerable higher in some subspecialties. According to a 1995 study of San Francisco Bay Area AIDS physicians, more than half of 188 doctors polled acknowledged having helped at least one patient to hasten his death. Henry, *supra* note 14, at 38.

doctors who have helped their patients end their lives have appeared both in professional journals[58] and in the daily press.[59]

The debate over whether terminally ill patients should have a right to reject medical treatment or to receive aid from their physicians in hastening their deaths has taken on a new prominence as a result of a number of developments. Two hundred years ago when America was founded and more than one hundred years ago when the Fourteenth Amendment was adopted, Americans died from a slew of illness and infirmities that killed their victims quickly but today are almost never fatal in this nation --- scarlet fever, cholera, measles, diarrhea, influenza, pneumonia, gastritis, to name a few. Other diseases that have not been conquered can now often be controlled for years, if not decades --- diseases such as diabetes, muscular dystrophy, Parkinson's disease, cardiovascular disease, and certain types of cancer. As a result, Americans are living longer, and when they finally succumb to illness, lingering longer, either in great pain or in a stuporous, semi-comatose condition that results from the infusion of vast amounts of

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[58] *See, e.g.*, Ann Japenga, *Should You Help a Patient Die?* Hippocrates 39 (Nov./Dec. 1994); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991); *It's Over, Debbie*, 259 J. Am. Med. Assoc. 272 (1988) (anonymous letter from doctor/author who administered a fatal dosage of morphine to a patient dying, painfully, of ovarian cancer, who asked for assistance).

[59] *See, e.g.*, Andrew Malcolm, To Suffer a Prolonged Illness or Elect to Die: A Case Study, N.Y. Times, Dec. 16, 1984, § 1, at 1, (describing woman with Lou Gehrig's disease whose death was secretly arranged to occur on a couch at home).

pain killing medications.[60] Despite the marvels of technology, Americans frequently die with less dignity than they did in the days when ravaging diseases typically ended their lives quickly. AIDS, which often subjects its victims to a horrifying and drawn-out demise, has also contributed to the growing number of terminally ill patients who die protracted and painful deaths.

[4] One result has been a growing movement to restore humanity and dignity to the process by which Americans die.[61] The now recognized right to refuse or terminate treatment and the emergent right to receive medical assistance in hastening one's death are inevitable consequences of changes in the causes of death, advances in medical science, and the development of new technologies. Both

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[60] As a result of medical advances, most Americans now die from slow acting ailments such as heart disease, cancer, and cerebrovascular disease. One in every two Americans dies of a disease diagnosed at least 29 months in advance; chronic conditions were the cause of more than 87% of the deaths in 1978. G. Steven Neeley, *Chaos In the "'Laboratory' of the States": The Mounting Urgency in The Call for Judicial Recognition of a Constitutional Right to Self-Directed Death*, 26 U. Tol. L. Rev. 81, * 3 (1994).

[61] Most Americans used to die at home, in the comfort of familiar surroundings, with their loved ones around them. No longer. In 1939, only 37 percent of Americans died in hospitals or nursing homes. Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-To Die Jurisprudence*, 25 U. Mich. J. L. Ref. 133, 154 (1991). Today, by contrast, between 80 and 85 percent of Americans die in institutions. *Id. citing* President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 17-18 (1983). About 70 percent of those who die in institutions do so after a decision to hasten their death by withholding or withdrawing medical treatment or technology. *Id. citing* Lisa Belkin, As Family Protests, Hospital Seeks an End to Woman's Life Support, N.Y. Times, Jan. 10, 1991, at A1.

the need and the capability to assist individuals end their lives in peace and dignity have increased exponentially.[62]

E.

Prior Court Decisions

[5] Next we examine previous Court decisions that delineate the boundaries of substantive due process. We believe that a careful examination of these decisions demonstrates that there is a strong liberty interest in determining how and when one's life shall end, and that an explicit recognition of that interest follows naturally, indeed inevitably, from their reasoning.

The essence of the substantive component of the Due Process Clause is to limit the ability of the state to intrude into the most important matters of our lives, at least without substantial justification.[63] In a long line of cases, the Court has carved out certain key moments and decisions in individuals' lives and placed them beyond the general prohibitory authority of the state. The Court has recog-

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[62] As a sidenote, President Francois Mitterrand of France, acknowledged universally as one of the contemporary world's greatest leaders, recently decided to hasten his death, only a short time after his voluntary retirement from office. He did so, after consulting with his doctor, by ceasing to take the medication that had not only been keeping him alive, but had enabled him to perform most of life's important tasks. As his doctor told him would be the case, he died three days later. President Mitterrand's decision was widely publicized and his final act was generally considered an act of courage and dignity. *See* Scott Kraft, Forsaking Cancer Medication, Mitterrand Wrote Own Final Chapter, L.A. Times, Jan. 13, 1996.

[63] When we refer to the Due Process Clause in this opinion, we refer to the due process clause of the Fourteenth Amendment, whether or not we include the reference to the specific numbered amendment. The due process clause of the Fifth Amendment, of course, provides *inter alia*, similar protection against comparable invasions by the federal government.

nized that the Fourteenth Amendment affords constitutional protection to personal decisions relating to marriage, *Loving v. Virginia*, 388 U.S. 1 (1967), procreation, *Skinner v. Oklahoma*, 316 U.S. 535 (1942), family relationships, *Prince v. Massachusetts*, 321 U.S. 158 (1944), child rearing and education, *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925), and intercourse for purposes other than procreation, *Griswold v. Connecticut*, 381 U.S. 479 (1965). The Court has recognized the right of individuals to be free from government interference in deciding matters as personal as whether to bear or beget a child, *Eisenstadt v. Baird*, 405 U.S. 438 (1972), and whether to continue an unwanted pregnancy to term, *Roe v. Wade*, 410 U.S. 113 (1973).[64]

[6] A common thread running through these cases is that they involve decisions that are highly personal and intimate, as well as of great importance to the individual.[65] Certainly, few decisions are more personal,

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[64] The dissent points to language in *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), referring to liberty interests that are such that "neither liberty nor justice would exist if they were sacrificed." That language, however, has never been applied literally. It would be difficult, if not impossible, for any fundamental right or liberty interest to meet such a standard. One could hardly argue for example that neither liberty nor justice would survive if contraceptives were banned, as they were for most of our history. Nor, indubitably, would even the most vigorous proponent of abortion rights argue that neither liberty nor justice existed in this nation prior to *Roe*.

[65] In this respect, *Bowers v. Hardwick*, 478 U.S. 186 (1986), would appear to be aberrant and to turn on the specific sexual act at issue. In *Bowers*, the Court held that the Constitution does not "confer[ ] a fundamental right upon homosexuals to engage in [homosexual] sodomy." 478 U.S. at 190. We do not believe that the *Bowers* holding controls the outcome here or is in any way inconsistent with our conclusion that there is a liberty interest in dying peacefully and with dignity. We also note, without surprise, that in the decade since

intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain. Accordingly, we believe the cases from *Pierce* through *Roe* provide strong general support for our conclusion that a liberty interest in controlling the time and manner of one's death is protected by the Due Process Clause of the Fourteenth Amendment.

While the cases we have adverted to lend general support to our conclusion, we believe that two relatively recent decisions of the Court, *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992) and *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), are fully persuasive, and leave little doubt as to the proper result.

F.

Liberty Interest under Casey

In *Casey*, the Court surveyed its prior decisions affording "constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education", *id.* at 2807 and then said:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Bowers was handed down the Court has never cited its central holding approvingly.

Id. at 2807. The district judge in this case found the Court's reasoning in *Casey* "highly instructive" and "almost prescriptive" for determining "what liberty interest may inhere in a terminally ill person's choice to commit suicide." *Compassion In Dying*, 850 F. Supp. at 1459. We agree.

[7] Like the decision of whether or not to have an abortion, the decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice "central to personal dignity and autonomy." A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Prohibiting a terminally ill patient from hastening his death may have an even more profound impact on that person's life than forcing a woman to carry a pregnancy to term. The case of an AIDS patient treated by Dr. Peter Shalit, one of the physician-plaintiffs in this case, provides a compelling illustration. In his declaration, Dr. Shalit described his patient's death this way:

> One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the

> excellent nursing care he received. Patient Smith begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that patient Smith was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the statute, I was unable to assist him and he died after having been tortured for weeks by the end-phase of his disease.[66]

For such patients, wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture. Surely, a person's decision whether to endure or avoid such an existence constitutes one of the most, if not the most, "intimate and personal choices a person may make in a lifetime," a choice that is "central to personal dignity and autonomy." *Casey*, 112 S. Ct. at 2807. Surely such a decision implicates a most vital liberty interest.

G.

Liberty Interest under Cruzan

In *Cruzan*, the Court considered whether or not there is a constitutionally-protected, due process liberty interest in terminating unwanted medical treatment. The Court said that an affirmative answer followed almost inevitably from its prior decisions holding that patients have a liberty interest in refusing to submit to specific medical procedures. Those cases include *Jacobsen v. Massachusetts*, 197 U.S. 11, 24-30 (1905), in which the Court balanced an individual's liberty interest in declining an unwanted small pox vaccine against the State's interest in preventing disease; *Washington v. Harper*, 494 U.S. 210, 221-222, in which the Court said: "The forcible injection

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[66] Declaration of Peter Shalit, M.D., at 5-6.

of medication into a nonconsenting person's body represents a substantial interference with that person's liberty"; and *Parham v. J.R.*, 442 U.S. 584, 600 (1979), in which it said: "[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment". Writing for a majority that included Justices O'Connor and Scalia, Chief Justice Rehnquist said that those cases helped answer the first critical question at issue in *Cruzan*, stating: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be *inferred* from our prior decisions." *Cruzan*, 497 U.S. at 278 (emphasis added).[67]

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[67] In a passage that has caused confusion among commentators, the Chief Justice later said that the Court would assume the existence of a constitutionally protected *right* to reject life-sustaining delivery of food and water for purposes of deciding the controversy presented in *Cruzan*. The Court stated:

> Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we *assume* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Cruzan, 497 U.S. at 279 (emphasis added). The passage is not inconsistent with, nor does it undermine, the Court's earlier statement that a due process liberty *interest* may be inferred from its prior holdings. Rather, the Court found a liberty *interest* and assumed a liberty *right*. That is, the Court recognized that an overall deprivation of the liberty interest would not be permissible and then assumed for purposes of deciding the ultimate issue before it that in the circumstances presented by *Cruzan* the interest resulted in a constitutional right and the state could not prohibit its exercise. *Cruzan*, 497 U.S. at 279. The ultimate question before the Court was whether or not

In her concurrence, Justice O'Connor explained that the majority opinion held (implicitly or otherwise) that a liberty interest in refusing medical treatment extends to all types of medical treatment from dialysis or artificial respirators to the provision of food and water by tube or other artificial means. As Justice O'Connor said: "I *agree* that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, and that the refusal of artificial delivery of food and water is encompassed in that liberty interest." *Cruzan*, 497 U.S. 261, 287, 287 (O'Connor, J., concurring) (emphasis added).

Justice O'Connor further concluded that under the majority's opinion, "[r]equiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment." *Id.* at 289 (O'Connor, J., concurring). In the majority opinion itself, Chief Justice Rehnquist made a similar assertion, writing:

> *The choice between life and death is a deeply personal decision of obvious and overwhelming finality.* We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. *It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.*

Cruzan, 497 U.S. at 281 (emphasis added).

Missouri could constitutionally require clear and convincing evidence of a comatose patient's previously stated wish not to be kept alive by artificial provision of food and water. The Court answered that question in the affirmative.

[8] These passages make it clear that *Cruzan* stands for the proposition that there is a due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means.[68] Moreover, the Court majority clearly recognized that granting the request to remove the tubes through which Cruzan received artificial nutrition and hydration would lead

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[68] Justice Scalia, despite explicitly joining the majority opinion appears to assert that a person has no liberty interest in rejecting forced nourishment, at least when doing so is tantamount, in his opinion, to committing suicide. *Cruzan*, 497 U.S. at 293-94 (Scalia, J., concurring). We have two comments in response to that assertion. First, we interpret Justice Scalia's statement as setting forth his view on a somewhat different point — one that the Court explicitly did not decide — when, whether, and under what circumstances Nancy Cruzan's exercise of a liberty interest could be prohibited by the state. Second, if we are wrong and Justice Scalia intended his statement to reflect an opposite view of the majority opinion to that stated by Justice O'Connor, his expression of his individual view cannot serve to change the opinion itself. In our view, Justice O'Connor's interpretation of the opinion is correct. Moreover, Justice Brennan, in a dissent joined by Justices Marshall and Blackmun, concluded that Nancy Cruzan has "a fundamental right to be free from unwanted artificial nutrition and hydration," *id.* at 302, as did Justice Stevens in his dissent, *id.* at 343. Thus, at least eight of the justices recognized a strong due process liberty interest in rejecting unwanted medical treatment, including the artificial provision of food and water.

Even if, however, the majority opinion had only recognized a liberty interest in refusing unwanted medical treatment without deciding whether or not that liberty interest encompasses the rejection of the artificial provision of food and water, five justices (Justice O'Connor, in her concurrence, and the four dissenting justices) still clearly found a liberty interest in rejecting the artificial provision of food and water. The Supreme Court has previously recognized that concurring and dissenting justices can constitute a controlling majority on a particular issue, at least where that view does not conflict with the holding of the majority. Here, there is no conflict of any kind with the majority opinion. *Marks v. United States*, 430 U.S. 188, 194 n.8 (1977).

inexorably to her death. *Cruzan*, 497 U.S. at 267-68, 283.[69] Accordingly, we conclude that *Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death.[70]

H.

Summary

[9] *Casey* and *Cruzan* provide persuasive evidence that the Constitution encompasses a due process liberty interest in controlling the time and manner of one's death — that there is, in short, a constitutionally recognized "right to die." Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness. *See* note 68 *supra*.

[10] Our conclusion that there is a liberty interest in determining the time and manner of one's death does not

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[69] It is also clear that the proposition recognized by *Cruzan* is one of general applicability and not limited to the terminally ill. *Id.* at 278. Indeed, Nancy Cruzan was not terminally ill, and as the Court noted, "[m]edical experts testified that she could live another thirty years." *Cruzan*, 497 U.S. at 266 n.1. Thus, the Court *could not* have resolved the case as it did by finding a liberty interest only in the terminally ill.

[70] Prior to the Court's decision in *Cruzan*, more than 15 states specifically prohibited implementing an advance directive that would have led to the termination of artificial nutrition and hydration. Alan Meisel, *The Right to Die* 369 & n.63 (1989). A few years after *Cruzan*, however, only a few states still prohibited the termination of nutrition and hydration as part of a living will, a prohibition that is probably unconstitutional under *Cruzan*. Alan Meisel, *The Right to Die; 1994 Cumulative Supplement No. 2* 395-99 (1994).

mean that there is a concomitant right to exercise that interest in all circumstances or to do so free from state regulation. To the contrary, we explicitly recognize that some prohibitory and regulatory state action is fully consistent with constitutional principles.

In short, finding a liberty interest constitutes a critical first step toward answering the question before us. The determination that must now be made is whether the state's attempt to curtail the exercise of that interest is constitutionally justified.

V.

Relevant Factors and Interests

To determine whether a state action that impairs a liberty interest violates an individual's substantive due process rights we must identify the factors relevant to the case at hand, assess the state's interests and the individual's liberty interest in light of those factors, and then weigh and balance the competing interests. The relevant factors generally include: 1) the importance of the various state interests, both in general and in the factual context of the case; 2) the manner in which those interests are furthered by the state law or regulation; 3) the importance of the liberty interest, both in itself and in the context in which it is being exercised; 4) the extent to which that interest is burdened by the challenged state action; and, 5) the consequences of upholding or overturning the statute or regulation.

A.

The State's Interests

We analyze the factors in turn, and begin by considering the first: the importance of the state's interests. We identify six related state interests involved in the controversy before us: 1) the state's general interest in

preserving life; 2) the state's more specific interest in preventing suicide; 3) the state's interest in avoiding the involvement of third parties and in precluding the use of arbitrary, unfair, or undue influence; 4) the state's interest in protecting family members and loved ones; 5) the state's interest in protecting the integrity of the medical profession; and, 6) the state's interest in avoiding adverse consequences that might ensue if the statutory provision at issue is declared unconstitutional.[71]

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[71] The majority of the three-judge panel identified five state interests. First, "[t]he interest in not having physicians in the role of killers of their patients." Second, "[t]he interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths." Third, "[t]he interest in protecting the poor and minorities from exploitation." Fourth, "[t]he interest in protecting all of the handicapped from societal indifference and apathy." Fifth, "[a]n interest in preventing abuse similar to what has occurred in the Netherlands where, since 1984, legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient." *Compassion In Dying*, 49 F.3d at 592-93. The district court, by contrast, employing more dispassionate and traditional terms, identified two somewhat broader state interests: preventing suicide and preventing undue influence and abuse. *Compassion In Dying*, 850 F. Supp. at 1464-65.

In two substituted judgment cases about halting the life-sustaining treatment of patients who were in or almost in a vegetative state, the Washington Supreme Court listed four possible countervailing state interests: 1) the preservation of life; 2) the protection of the interests of innocent third parties; 3) the prevention of suicide; and 4) the maintenance of the integrity of the medical profession. *In re Guardianship of Grant*, 747 P.2d 455, 451 (Wash. 1987); *In re Colyer*, 660 P.2d. 738, 743 (Wash. 1983).

In *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728 (1977), one of several state supreme court cases discussed in *Cruzan*, the state court found four state interests: preservation of life, protection of the interests of innocent third parties, the prevention

1. Preserving Life

The state may assert an unqualified interest in preserving life in general. As the Court said in *Cruzan*, "we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . ." *Cruzan*, 497 U.S. at 282. Thus, the state may assert its interest in preserving life in all cases, including those of terminally ill, competent adults who wish to hasten their deaths.

Although the state's interest in preserving life may be unqualified, and may be asserted regardless of the quality of the life or lives at issue, that interest is not always controlling.[72] Nor is it of the same strength in each case. To the contrary, its *strength* is dependent on relevant circumstances, including the medical condition and the wishes of the person whose life is at stake.

Most tellingly, the state of Washington has already decided that its interest in preserving life should ordinarily give way — at least in the case of competent, terminally ill adults who are dependent on medical treatment — to the wishes of the patients. In its Natural Death Act, RCW 70.122.020 *et seq.*, Washington permits adults to have "life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious-

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of suicide, and the maintenance of the ethical integrity of the medical profession. *Cruzan*, 497 U.S. at 271.

[72] Were it otherwise no state could administer capital punishment; similarly, the draft, as well as the defense budget, would be unconstitutional.

ness." RCW 70.122.010.[73] In adopting the statute, the Washington legislature necessarily determined that the state's interest in preserving life is not so weighty that it ought to thwart the informed desire of a terminally ill, competent adult to refuse medical treatment.

Not only does Washington law acknowledge that terminally ill and permanently unconscious adults have a right to refuse life-sustaining treatment, the statute includes specific legislative findings that appear to recognize that a due process liberty interest underlies that right. The statute states:

> The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances of terminal condition.
>
> The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.
>
> The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause

[73] The statute, enacted in 1979, includes the following definition of terminal condition:

> "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW 70.122.020(9).

> loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

RCW 70.122.010.[74]

The Washington statute permits competent adults to reject life-sustaining medical treatment in advance by means of living wills and durable powers of attorney. RCW 70.122.010-030. Even in cases in which the Washington Natural Death Act does not authorize surrogate decision-making, the Washington Supreme Court has found that legal guardians may sometimes have life-sustaining treatment discontinued. *In re Guardianship of Grant*, 747

[74] Other states have recognized liberty interests similar to those recognized by Washington. *See e.g.* Ala. Code § 22-8A-2 (1995) (stating that adults have a "fundamental right" to control decisions relating to the rendering of their own medical care even when no longer able to participate actively in those decisions); Alaska Stat. § 18.12.100 (1995) (recognizing that some medical procedures "serve only to prolong the dying process"); Cal. Health & Safety Code § 7185.5 (West 1996) (finding that adults have "fundamental right" to control decisions affecting their medical care and recognizing that continued, unwanted medical treatment "violate[s] patient dignity and cause[s] unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the person"); Ga. Code Ann. § 3132-1 (1995) (protecting patient autonomy from loss of dignity and unnecessary pain and suffering); 19 Haw. Rev. Stat. § 327D-1 (recognizing that "artificial prolongation of life for persons with a terminal condition . . . secure[s] only a precarious and burdensome existence"); La. Rev. Stat. Ann. § 1299.58.1 (West 1995) (stating that unwanted artificial prolongation causes a "loss of individual and personal dignity and secure[s] only a precarious and burdensome existence while providing nothing medically necessary or beneficial"); Nev. Rev. Stat. § 449.570 (1991) (recognizing unwanted treatment only prolongs dying process); Utah Code Ann. § 752-1102 (1995) (finding that all persons should be entitled "to die with a maximum of dignity and a minimum of pain").

P.2d 445 (Wash. 1987); *In re Colyer*, 660 P.2d 738 (Wash. 1983).[75]

There is nothing unusual about Washington's recognition that the state's interest in preserving life is not always of the same force and that in some cases at least other considerations may outweigh the state's.[76] More than 40 other states have adopted living will statutes that permit competent adults to declare by advance directive that they do not wish to be kept alive by medical treatment in the latter stages of a terminal illness.[77] Like Washington,

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[75] A "living will" permits a competent adult to direct in advance that under certain specific circumstances future life-sustaining treatment should be withheld or terminated. A "durable power of attorney" for health care decisions allows a competent adult to designate someone else to make future medical decisions for him should he lose the capacity to make them himself. In cases in which an incompetent individual has not completed a living will or executed a durable power of attorney, some states permit the courts to appoint a guardian to make medical decisions on his behalf.

[76] In *Grant*, the Washington Supreme Court said that the state's interest in preserving life "weakens considerably, however, if treatment will merely postpone death for a person with a terminal and incurable condition." 747 P.2d at 451; In *Colyer*, the Washington Supreme Court held that the state's interest in preserving life "weakens, however, in situations where continued treatment only serves to prolong a life inflicted with an incurable condition." 660 P.2d at 743.

[77] The following lists comes from Alan Meisel, *The Right to Die* § 11.12 (1989 & 1994 Supp. No.2):

> Ala. Code § 22-8A-3(6) (1984); Alaska Stat. § 18.12.100(7) (1986); Ark. Stat. Ann. § 20-17-201(9) (Supp. 1987); Cal. Health & Safety Code § 7186(j) (West Supp. 1992); Colo. Rev. Stat. § 15-18-103(10) (1987 & Supp. 1992); Conn. Gen. Stat. Ann. § 19a-570(3) (West Supp. 1993); Del. Code Ann. tit. 16, § 2501 (e) (1983); D.C. Code Ann. § 6-2421(6) (Supp. 1987); Fla. Stat. Ann. § 765.101(17) (West Supp. 1993); Ga. Code

many states also permit competent adults to determine in advance that they do not wish any medical treatment should

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> Ann. § 31-32-2(13) (1991 & Supp. 1992); Haw. Rev. Stat. Ann. § 327D-2 (1991); Ill. Ann. Stat. ch. 110 §, para. 702(h) (Smith-Hurd Supp. 1988); Ind. Code Ann. § 16-8-11-9 (Burns Supp. 1988); Iowa Code Ann. § 144A.2(8) (West 1989 & Supp.); La. Rev. Stat. Ann. § 40:1299.58.2(9) (West 1992); Me. Rev. Sta. Ann. tit. 18-A, § 5-701(b)(9) (West Supp. 1991); Md. Health-Gen. Code Ann. § 5-601(g) (1990); Minn. Stat. Ann. § 145B.02(8) (West Supp. 1993); Miss. Code Ann. § 41-41-113 (Supp. 1987); Mo. Ann. Stat. § 459.010(6) (Vernon Supp. 1993); Mont. Stat. Ann. § 50-9-102(14) (1991); Neb. Rev. Stat. § 20-403(11) (Supp. 1992); Nev. Rev. Stat. Ann. § 449.590 (Michie Supp. 1991); N.H. Rev. Stat. Ann. § 137-H:2(VI) (Supp. 1992); N.J. Stat [sic] Ann. § 26:2H-55 (West Supp. 1992) ("A determination of a specific life expectancy is not required as a precondition for a diagnosis of a 'terminal condition,' but a prognosis of a life expectancy of six months or less, with or without the provision of life-sustaining treatment, based upon reasonable medical certainty, shall be deemed to constitute a terminal condition."); N.M. Stat. Ann. § 24-7-2(f) (1986); N.D. Cent. Code § 23-06.4-02.7 (Supp. 1989); Ohio Rev. Code Ann. § 2133.01(AA) (Anderson 1991); Okla. Stat. Ann. tit. 63, § 3101.3(12) (West Supp. 1993); Or. Rev. Stat. Ann. § 127.605(6) (1990); 20 Pa. Cons. Stat. Ann. § 5403 (Supp.); R.I. Gen. Laws § 23-4.11-2(h) (Supp. 1992); S.C. Code Ann. S 44-77-20(4) (Law. Co-op. Supp. 1988); Tenn. Code. Ann. § 32-11-103(9) (Supp. 1991); Tex. Health & Safety Code Ann. § 672.003(9) (West 1992); Utah Code Ann. § 75-2(10) (Michie Supp. 1993); Vt. Stat. Ann. tit. 18, § 5252(5) (1987); Va. Code Ann. § 54.1-2982 (Michie Supp. 1992); Wash. Rev. Code Ann. § 70.122.020(9) (West Supp.); W. Va. Code § 16-30-2(6) (1985); Wis. Stat. Ann. § 154.01(8) (West 1989 & Supp. 1992); Wyo. Stat. § 35-22-101(a)(ix) (1988 & Supp. 1992); see also Uniform Rights of the Terminally Ill Act, § 1(9), 9B U.L.A. 96, 98 (Supp. 1992).

they become permanently and irreversibly unconscious.[78]

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[78] Meisel, *supra* note 77, (1989 & 1994 Supp. No. 2) § 11.12 notes that the Uniform Rights of the Terminally Ill Act permits the foregoing of treatment when the patient is in a persistent vegetative state. Meisel also states:

> An increasing number of states now define *terminal condition* to include permanent or persistent vegetative state and/or irreversible coma. *See, e.g.*, Conn. Gen. Stat. Ann. § 19a-570(3) (West Supp. 1993); Fla. Stat. Ann. § 765.101(17)(b) (West Supp. 1993); Iowa Code Ann. § 144A/2(8) (West 1989 & Supp.) (state of permanent unconsciousness); La. Rev. Stat. Ann. § 40:1299.58.2(7) (West 1992); Neb. Rev. Stat. § 20-403(11) (Supp. 1992); Nev. Rev. Stat. Ann. § 449.590 (Michie 1991); Ohio Rev. code Ann. § 2133.01(U) (Anderson Supp. 1991); R.I. Gen. Laws § 23.411-2(h) (Supp. 1992); Tenn. Code Ann. § 32-11-103 (9) (Supp. 1991); Va. Code Ann. § 54.1-2982 (Michie Supp. 1992). Other statutes reach the same result by defining *qualified patient* as one who is in a terminal condition or a persistent vegetative state. *See, e.g.*, Cal. Health & Safety Code § 7186(h) (west Supp. 1992); Colo. Rev. Stat. § 15-18-103(9) (1987 & Supp. 1992); Iowa Code Ann. § 144A.2(7) (West 1989 & Supp.); Me. Rev. Stat. Ann. titl. 18A, § 5 701(b)(7) (West Supp. 1991); Neb. Rev. Stat. § 20-403(9) (Supp. 1992); Nev. Rev. Stat. Ann. § 449.585 (Michie Supp. 1991); N.H. Rev. Stat. Ann. § 137-H:2(V) (Supp. 1992); Ohio Rev. Code Ann. § 2133.01(Z) (Anderson Supp. 1991); Okla. Stat. Ann. titl. 63, § 3101.3(10) (West Supp. 1993); Or. Rev. Stat. Ann. § 127.605(5) (1990); 20 Pa. Cons. Stat. Ann. § 5403 (Supp.); Tex. Health & Safety code Ann. § 672.002(8) (West 1992); Wash. Rev. Code Ann. § 70.122.020(8) (West Supp.); Wis. Stat. Ann. § 154.01(6) (West 1989 & 1992 Supp.). The amended Hawaii statute, however, achieves this result by deleting the definition of "qualified patient" and adding a definition of "permanent loss of the ability to communicate concerning medical treatment decisions" which includes being in a persistent vegetative state or a deep coma or having a permanent loss of the capacity to participate in medical treatment decisions. *See* Haw. Rev. Stat. Ann. § 327D-2 (1991). Still other statutes reach the same result by including a separate definition of *persistent vegetative state* or *permanent unconsciousness*. *See, e.g.*, Conn. Gen. Stat. Ann. § 19a-570(4) (West Supp. 1993); Ga. Code Ann. § 31-32-2(9) (1991 & Supp. 1992); Me. Rev. Stat. Ann. titl. 18A, § 5-701(b)(10) (West Supp. 1991); Md. Health-Gen. code Ann. § 5-601(0); Neb. Rev. Stat. § 20-403(6) (Supp. 1992); N.H. Rev. Stat. Ann. § 137-H:2(VII) (Supp. 1992); N.J. Stat. Ann. § 26:2H-55 (West Supp. 1992); Okla. Stat. Ann. tit. 63, § 3101.3(7) (West Supp. 1993) (defines *persistently unconscious*); 20 Pa. Cons. Stat. Ann. § 5403 (Supp.); S.C. Code Ann. § 44-77-20(7) (Law. Co-op Supp. 1991); Utah Code Ann. § 75-2-1103(8) (Michie Supp. 1993); Va. Code Ann. § 54.1-2982 (Michie supp. 1992); Wash. Rev. Code Ann. § 70.122.020(6) (West Supp.) (permanent unconscious condition); Wis. Stat. Ann. § 154.01(5m) (West 1989 & Supp. 1992); Wyo. Stat. § 35-22-101(a)(v) (1988 & Supp. 1992) ("irreversible coma").

Id.

Also, like Washington, many states allow patients to delegate decision-making power to a surrogate through a durable power of attorney, health care proxy, or similar device, or permit courts to appoint surrogate decision-makers.[79] Finally, Congress favors permitting adult patients to refuse life-sustaining treatment by advance directive and requires hospitals receiving federal financial support to notify adult patients of their rights to execute such instruments upon admission.[80]

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[79] Meisel, *supra* note 77, *1994 Cumulative Supplement No. 2*, §§ 10A.1-10A.2.

[80] The Federal Patient Self-Determination Act, passed in 1990, requires all health care providers receiving Medicaid or Medicare to inform all competent adult patients, even those admitted for the simplest of procedures, about state laws on advance directives and to record any advance directives the patient might have. Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206, 104 Stat. 1388-115 (codified at 42 U.S.C.A. § 1395cc(f)) (West 1992 & Supp. 1995).

[11] As the laws in state after state demonstrate, even though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die without further medical treatment (or if a duly appointed representative has done so on his behalf). When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling. Thus, while the state may still seek to prolong the lives of terminally ill or comatose patients or, more likely, to enact regulations that will safeguard the manner in which decisions to hasten death are made, the strength of the state's interest is substantially reduced in such circumstances.

2. Preventing Suicide

a.

While the state's general commitment to the preservation of life clearly encompasses the prevention of suicide, the state has an even more particular interest in deterring the taking of one's own life. The fact that neither Washington nor any other state currently bans suicide, or attempted suicide, does not mean that the state does not have a valid and important interest in preventing or discouraging that act.

During the course of this litigation, the state has relied on its interest in the prevention of suicide as its primary justification for its statute.[81] The state points to statistics concerning the rate of suicide among various age groups,

[81] For that reason, we include in this section an analysis, a large portion of which could just as appropriately have been included in the preceding section, treating the state's interest in preserving life.

particularly the young. *Compassion In Dying*, 850 F. Supp. at 1464. As the state notes, in 1991, suicide was the second leading cause of death after accidents for the age groups 15-19, 20-24, and 25-34 and one of the top five causes of death for age groups 35-44 and 45-54.[82] These figures are indeed distressing.

Although suicide by teenagers and young adults is especially tragic, the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated. Studies show that many suicides are committed by people who are suffering from treatable mental disorders. Most if not all states provide for the involuntary commitment of such persons if they are likely to physically harm themselves. For similar reasons, at least a dozen states allow the use of nondeadly force to prevent suicide attempts.[83]

[12] While the state has a legitimate interest in preventing suicides in general, that interest, like the state's interest in preserving life, is substantially diminished in the case of

[82] Washington State Dep't of Health, *Washington State Annual Summary of Vital Statistics 1991* (October, 1992).

[83] *See* Alaska Stat. § 11.81.430(a)(4) 1983; Ark. Code Ann. § 5-2-605(4) (1987); Colo. Rev. Stat. § 18-1-703(1)(d) (1986); Haw. Rev. Stat. § 703-308(1) (1985); Ky. Rev. Stat. § 503.100(1)(a) (1985); Mo. Ann. Stat. § 563.016(5) (Vernon 1979); N.H. Rev. Stat. § 627:6(vi); N.J. Stat. Ann. § 2C:3-7(e) (West 1982); N.Y. Penal § 35.10(4) (McKinney 1987); Or. Rev. § 161.209 (Repl. 1983); 18 Pa. Cons. Stat. Ann. § 508(d) (Purdon 1983); Wis. Stat. Ann. § 939.48(5) (West 1982).

terminally ill, competent adults who wish to die.[84] One of the heartaches of suicide is the senseless loss of a life ended prematurely. In the case of a terminally ill adult who ends his life in the final stages of an incurable and painful degenerative disease, in order to avoid debilitating pain and a humiliating death, the decision to commit suicide is not senseless, and death does not come too early.[85] Unlike "the depressed twenty-one year old, the romantically devastated twenty-eight year old, the alcoholic forty-year old," *Compassion In Dying*, 49 F.3d at 590-91, or many others who may be inclined to commit suicide, a terminally ill competent adult cannot be cured. While some people who contemplate suicide can be restored to a state of physical and mental well-being, terminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends. Not only is the state's interest in preventing such individuals from hastening their deaths of comparatively little weight, but its insistence on frustrating their

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[84] For an extended discussion of the arguments for and against legalizing physicians-assisted suicide, see generally The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) and Michigan Commission On Death and Dying, *Final Report*, (June 1994). The New York States Task Force recommended retaining that state's prohibition on assisted suicide; the Michigan Commission recommended decriminalizing physician-assisted suicide under some circumstances.

[85] Many terminally ill patients would probably identify with Marcus Aurelius, a Roman emperor and stoic philosopher, who wrote: "It is a shame when the soul is first to give way in this life, and the body does not give way." Marcus Aurelius, *Meditations*, In Marcus Aurelius and His Times 61 (G. Long trans., 1973).

wishes seems cruel indeed.[86] As Kent said in *King Lear*, when signs of life were seen in the dying monarch:

> Vex not his ghost: O! let him pass; he hate him
> That would upon the rack of this tough world Stretch
> him out longer.[87]

b.

[13] The state has explicitly recognized that its interests are frequently insufficient to override the wishes of competent, terminally ill adult patients who desire to bring their lives to an end with the assistance of a physician. Step by step, the state has acknowledged that terminally ill persons are entitled in a whole variety of circumstances to hasten their deaths, and that in such cases their physicians may assist in the process. Until relatively recently, while physicians routinely helped patients to hasten their deaths, they did so discreetly because almost all such assistance was illegal. However, beginning about twenty years ago a series of dramatic changes took place. Each provoked the type of division and debate that surrounds the issue

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[86] While recognizing the state's general interest in preventing suicide, the district court in this case said that it did not apply in the case of terminally ill, competent adults who wished to hasten their deaths. The court said:

> As to them, preventing suicide simply means prolonging a dying person's suffering, an aim in which the State can have no interest. In other words, the State's legitimate interest in preventing suicide is not abrogated by allowing mentally competent terminally ill patients to freely and voluntarily commit physician-assisted suicide.

Compassion In Dying, 850 F. Supp. at 1464.

[87] *King Lear*, act V. sc. iii, ll. 314-316, cited in Richard Posner, *Age and Old Age* 239 & n. 11 (1995).

before us today. Each time the state's interests were ultimately subordinated to the liberty interests of the individual, in part as a result of legal actions and in part as a result of a growing recognition by the medical community and society at large that a more enlightened approach was essential.

The first major breakthrough occurred when the terminally ill were permitted to reject medical treatment.[88] The line was drawn initially at extraordinary medical treatment because the distinction between ordinary and extraordinary treatment appeared to some to offer the courts an objective, scientific standard that would enable them to recognize the right to refuse certain medical treatment without also recognizing a right to suicide or euthanasia.[89] That distinction, however, quickly proved unworkable, and after a while, terminally ill patients were allowed to reject *both* extraordinary and ordinary treatment. For a while, *rejection* of treatment, often through "do not resuscitate" orders, was permitted, but *termination* was not. This dividing line, which rested on the illusory distinction between commission and omission (or active and passive), also appeared for a short time to offer a natural point of repose for doctors, patients and the law. However, it, too, quickly proved untenable, and ultimately patients were allowed both to *refuse* and to *terminate* medical treat-

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[88] *See, e.g., Satz v. Perlmutter*, 362 So.2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980).

[89] Lawrence H. Tribe, *Governmental Control Over the Body: Decisions About Death and Dying*, American Constitutional Law § 15-11 (2d ed. 1988).

ment,[90] ordinary as well as extraordinary. Today, many states also allow the terminally ill to order their physicians to discontinue not just traditional medical treatment but the artificial provision of life-sustaining food and water, thus permitting the patients to die by self-starvation. Equally important, today, doctors are generally permitted to administer death-inducing medication, as long as they can point to a concomitant pain-relieving purpose.

In light of these drastic changes regarding acceptable medical practices, opponents of physician-assisted suicide must now explain precisely what it is about the physician's conduct in assisted suicide cases that distinguishes it from the conduct that the state has explicitly authorized. The state responds by urging that physician-assisted suicide is different in kind, not degree, from the type of physician-life-ending conduct that is now authorized, for three separate reasons. It argues that "assisted suicide": 1) requires doctors to play an active role; 2) causes deaths that would not result from the patient's underlying disease; and 3) requires doctors to provide the causal agent of patients' deaths.

The distinctions suggested by the state do not individually or collectively serve to distinguish the medical practices society currently accepts. The first distinction — the line between commission and omission — is a distinction without a difference now that patients are

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[90] *See* Alan Meisel, *The Right to Die* § 4.4 "Withholding and Withdrawing Treatment" (1989). *See also In Re Conroy*, 486 A.2d 1209, 1234 (N.J. 1985) (noting that "from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die.").

permitted not only to decline all medical treatment, but to instruct their doctors to *terminate* whatever treatment, artificial or otherwise, they are receiving. In disconnecting a respirator, or authorizing its disconnection, a doctor is unquestionably *committing* an act; he is taking an active role in bringing about the patient's death. In fact, there can be no doubt that in such instances the doctor intends that, as the result of his action, the patient will die an earlier death than he otherwise would.

Similarly, drawing a distinction on the basis of whether the patient's death results from an underlying disease no longer has any legitimacy. While the distinction may once have seemed tenable, at least from a metaphysical standpoint, it was not based on a valid or practical legal foundation and was therefore quickly abandoned. When Nancy Cruzan's feeding and hydration tube was removed, she did not die of an underlying disease. Rather, she was allowed to starve to death.[91] In fact, Ms. Cruzan was not

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[91] As the Missouri Supreme Court starkly put it:

> This is also a case in which euphemisms readily find their way to the fore, perhaps to soften the reality of what is really at stake. But this is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill. *This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration.*

Cruzan By Cruzan v. Harmon, 760 S.W.2d 408, 412 (1988) (emphasis added). The facts corroborate the Missouri Supreme Court's assertion. Nancy Cruzan was kept alive through artificial feeding for nearly eight years. After the United States Supreme Court remanded the case, a Missouri court determined that she had expressed a clear wish before her accident not to be kept alive by artificial means and ordered a halt to the artificial feeding. She died twelve days later. Cathaleen A. Roach, *Paradox and Pandora's Box: The Tragedy of Current Right-To-Die Jurisprudence*, 25 U. Mich. J.L. Ref. 133, 138 (1991), citing

even terminally ill at the time, but had a life expectancy of 30 years.[92] Similarly, when a doctor provides a conscious patient with medication to ease his discomfort while he starves himself to death -- a practice that is not only legal but has been urged as an alternative to assisted suicide[93] -- the patient does not die of any underlying ailment. To the contrary, the doctor is helping the patient end his life by providing medication that makes it possible for the patient to achieve suicide by starvation.

Nor is the state's third and final distinction valid. Contrary to the state's assertion, given current medical practices and current medical ethics, it is not possible to distinguish prohibited from permissible medical conduct on the basis of whether the medication provided by the doctor will cause the patient's death. As part of the tradition of administering comfort care, doctors have been supplying the causal agent of patients' deaths for decades. Physicians routinely and openly provide medication to terminally ill patients with the knowledge that it will have a "double

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Cruzan v. Mouton Estate No. CV384-9P (Mo. Cir. Ct. Dec. 14, 1990). As the Missouri Supreme Court told us would be the case, it was the discontinuance of the provision of food and water, not Cruzan's accident almost eight years earlier, that caused her death. Thus, Nancy Cruzan did not die from an underlying illness, but from deliberate self-starvation.

[92] The removal of the gastronomy tube, which was clearly the precipitating cause of her death, is not considered to be the legal cause only because a judicial judgment has been made that removing the feeding tube is permissible. *See* Note, *Physician-Assisted Suicide and the Right to Die With Assistance*, 105 Harv. L. Rev. 2021, 2029-31 (1992).

[93] *See* James L. Bernat, M.D., et al., Commentary, *Patient Refusal of Hydration and Nutrition: An Alternative to Physician-Assisted Suicide or Voluntary Active Euthanasia* 153 Archives Internal Med. 2723 (1993).

effect" — reduce the patient's pain and hasten his death.[94] Such medical treatment is accepted by the medical profession as meeting its highest ethical standards.[95] It commonly takes the form of putting a

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[94] *Decisions Near the End of Life*, a report by the Council on Ethical and Judicial Affairs of the American Medical Association, provides an informative discussion of "double effect." An abridged version of the report, published in the Journal of American Medicine described the Council's conclusions this way:

> The Council stated in its 1988 report that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life." The Council maintains this position and further emphasizes that a competent patient must be the one who decides whether the relief from pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

Council on Ethical and Judicial Affairs, American Medical Association, 54 *Decisions Near the End of Life*, 267 The Journal of the American Medical Association (April 22-29 1992).

[95] Timothy E. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* 107-108 (1993). The term "double effect" originates in Roman Catholic moral theology, which holds that it is sometimes morally justifiable to cause evil in the pursuit of good. *See* May, Double Effect, in Encyclopedia of Bioethics 316 (W. Reich ed. 1978).

See also Report of the Council on Ethical and Judicial Affairs of the American Medical Association, 10 Issues L. & Med. 91 (1994). In its report, the Council said:

> The intent of palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to *gradually increase* the appropriate medication for a patient, realizing that the medication may

patient on an intravenous morphine drip, with full knowledge that, while such treatment will alleviate his pain, it will also indubitably hasten his death.[96] There can be no doubt, therefore, that the actual cause of the patient's death is the drug administered by the physician or by a person acting under his supervision or direction. Thus, the causation argument is simply "another bridge crossed" in the journey to vindicate the liberty interests of the terminally ill, and the state's third distinction has no more force than the other two.

c.

[4] We acknowledge that in some respects a recognition of the legitimacy of physician-assisted suicide would constitute an additional step beyond what the courts have previously approved. We also acknowledge that judicial acceptance of physician-assisted suicide would cause many sincere persons with strong moral or religious convictions great distress. Nevertheless, we do not believe that the state's interest in preventing that additional step is

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> depress respiration and cause death.

Id. at 92 (emphasis added). The euphemistic use of "possible" and "may" may salve the conscience of the AMA, but it does not change the realities of the practice of medicine or the legal consequences that would normally flow from the commission of an act one has reason to believe will likely result in the death of another. In the case of "double effect" we excuse the act or, to put it more accurately, we find the act acceptable, not because the doctors sugarcoat the facts in order to permit society to say that they couldn't really *know* the consequences of their action, but because the act is medically and ethically appropriate even though the result — the patient's death — is both foreseeable and intended.

[96] Analgesics, most notably morphine, when applied in sufficient doses, will bring about a patient's death because they serve to repress respiration.

significantly greater than its interest in preventing the other forms of life-ending medical conduct that doctors now engage in regularly. More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other. In sum, we find the state's interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention. To the extent that a difference exists, we conclude that it is one of degree and not of kind.

d.

Moreover, we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as "suicide." Certainly, we see little basis for such a classification when deaths that result from patients' decisions to terminate life support systems or to refuse life-sustaining food and water, for example, are not. We believe that there is a strong argument that a decision by a terminally ill patient to hasten by medical means a death that is already in process, should not be classified as suicide. Thus, notwithstanding the generally accepted use of the term "physician-assisted suicide," we have serious doubt that the state's interest in preventing suicide is even implicated in this case.

e.

[15] In addition to the state's purported interest in preventing suicide, it has an additional interest in preventing deaths that occur as a result of errors in medical or legal judgment. We acknowledge that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is sometimes impossible to say for certain whether a borderline individual is or is not mentally competent.[97] However, we believe that sufficient safeguards can and will be developed by the state and medical profession, *see infra* p. 3204, to ensure that the possibility of error will ordinarily be remote. Finally, although life and death decisions are of the gravest order, should an error actually occur it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most desirable.[98]

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[97] *See generally* Harold G. Koenig, *Legalizing Physician-Assisted Suicide: Some Thoughts and Concerns*, 37 J. Fam. Prac. 171 (1993).

[98] There is some evidence that the state's efforts to prohibit assisted suicide in hopes of deterring suicide is at least partially counter-productive. As a result of the state's ban, some terminally ill adults probably commit suicide although they otherwise might not have done so and others probably commit suicide sooner than they would have done so.

In his recent book, Judge Richard Posner suggests that "permitting physician-assisted suicide . . . [in] cases of physical incapacity might actually *reduce* the number of suicides and *postpone* the suicides that occur." Posner, *infra* note 87, at 224. Judge Posner concludes that assuring such individuals that they would be able to end their lives later if they wished to, even if they became totally physically incapacitated, would deter them from committing suicide now and would also give such people a renewed peace of mind. He says that some of those individuals would eventually commit suicide but others would decide never to do so. *Id.* 243-253.

3. Avoiding the Involvement of Third Parties, and Precluding the Use of Arbitrary, Unfair, or Undue Influence

a.

A state may properly assert an interest in prohibiting even altruistic assistance to a person contemplating suicide on the grounds that allowing others to help may increase the incidence of suicide, undercut society's commitment to the sanctity of life, and, adversely affect the person providing the assistance. In addition, joint action is generally considered more serious than action by a single person. While we recognize that these concerns are legitimate, the most important -- the first two -- diminish in importance to the same extent that the state's interest in preventing the act itself diminishes. All are at their minimums when the assistance is provided by or under the supervision or direction of a doctor and the recipient is a terminally ill patient.

[16] In upholding Washington's statute, the majority of the three-judge panel relied heavily on the state's interest in preventing the exercise of undue, arbitrary or unfair influences over the individual's decision to end his life. *Compassion In Dying*, 49 F.3d at 592-93. We agree that this is an important interest, but for entirely different reasons than the majority suggests. One of the majority's prime arguments is that the statute is necessary to protect "the poor and minorities from exploitation," 49 F.3d at 592

The suicide of Nobel Prize winning physicist Percy Bridgman, recounted in one of the amicus briefs, graphically illustrates the point. Dr. Bridgman, 79, was in the final stages of cancer when he shot himself on August 20, 1961, leaving a suicide note that said: "It is not decent for society to make a man do this to himself. Probably this is the last day I will be able to do it myself." Sherman B. Nuland, *How We Die*, 152-53 (1993).

-- in other words, to protect the disadvantaged from becoming the victims of assisted suicide. This rationale simply recycles one of the more disingenuous and fallacious arguments raised in opposition to the legalization of abortion.[99] It is equally meretricious here. In fact, as with abortion, there is far more reason to raise the opposite concern: the concern that the poor and the minorities, who have historically received the least adequate health care, will not be afforded a fair opportunity to obtain the medical assistance to which they are entitled -- the assistance that would allow them to end their lives with a measure of dignity. The argument that disadvantaged persons will receive *more* medical services than the remainder of the population in one, and only one, area -- assisted suicide -- is ludicrous on its face. So, too, is the argument that the poor and the minorities will rush to volunteer for physician-assisted suicide because of their inability to secure adequate medical treatment.

Our analysis is similar regarding the argument relating to the handicapped. Again, the opponents of physician-assisted suicide urge a variation of the discredited anti-

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[99] The argument there was that the poor and the minorities would either be persuaded to have too many abortions or would be forced to have them against their will: The fact is that the poor and the minorities have been disproportionately deprived of the opportunity to have abortions, not only because they cannot afford such operations, but because in numerous instances restrictive legislation, sponsored by those who oppose abortion rights, prohibits the use of public funds to pay for them. *See, e.g.*, 42 U.S.C. § 300a-6 (prohibiting the use of Title X grants in programs in which abortions are performed or abortion counseling is offered); *Planned Parenthood Affiliates of Cal. v. Swoap*, 173 Cal. App. 3d 1187 (Cal. Ct. App. 1985) (holding that section of state budget act containing restrictive language regarding use of family planning funds for abortion-related services violated the state constitution).

abortion argument. Despite the dire predictions, the disabled were not pressured into seeking abortions. Nor is it likely that the disabled will be pressured into committing physician-assisted suicide. Organizations representing the physically impaired are sufficiently active politically and sufficiently vigilant that they would soon put a halt to any effort to employ assisted suicide in a manner that affected their clients unfairly. There are other more subtle concerns, however, advanced by some representatives of the physically impaired, including the fear that certain physical disabilities will erroneously be deemed to make life "valueless." While we recognize the legitimacy of these concerns, we also recognize that seriously impaired individuals will, along with non-impaired individuals, be the beneficiaries of the liberty interest asserted here —- and that if they are not afforded the option to control their own fate, they like many others will be compelled, against their will, to endure unusual and protracted suffering. The resolution that would be best for all, of course, would be to ensure that the practice of assisted suicide is conducted fairly and well, and that adequate safeguards sufficient to avoid the feared abuses are adopted and enforced.

b.

[17] There is a far more serious concern regarding third parties that we must consider -— one not even mentioned by the majority in the panel opinion. That concern is the fear that infirm, elderly persons will come under undue pressure to end their lives from callous, financially burdened, or self-interested relatives, or others who have influence over them. The risk of undue influence is real —- and it exists today. Persons with a stake in the outcome may now pressure the terminally ill to reject or decline life-saving treatment or take other steps likely to hasten their demise. Surrogates may make unfeeling life and death decisions for their incompetent relatives. This

concern deserves serious consideration, as it did when the decision was made some time ago to permit the termination of life-support systems and the withdrawal or withholding of other forms of medical treatment, and when it was decided to recognize living wills, durable powers of attorney, and the right of courts to appoint substitute decision-makers. While we do not minimize the concern, the temptation to exert undue pressure is ordinarily tempered to a substantial degree in the case of the terminally ill by the knowledge that the person will die shortly in any event. Given the possibility of undue influence that already exists, the recognition of the right to physician-assisted suicide would not increase that risk unduly. In fact, the direct involvement of an impartial and professional third party in the decision-making process would more likely provide an important safeguard against such abuse.

We also realize that terminally ill patients may well feel pressured to hasten their deaths, not because of improper conduct by their loved ones, but rather for an opposite reason -- out of concern for the economic welfare of their loved ones. Faced with the prospect of astronomical medical bills, terminally ill patients might decide that it is better for them to die before their health care expenses consume the life savings they planned to leave for their families, or, worse yet, burden their families with debts they may never be able to satisfy. While state regulations can help ensure that patients do not make rash, uninformed, or ill considered decisions, we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration.

Throughout its analysis, the dissent relies heavily on Professor Kamisar, a long-time, outspoken, and nationally

recognized opponent of assisted-suicide. Following Professor Kamisar's lead, our dissenting colleagues suggest that the nation's priorities are misplaced because some of the problems we address result from the "lack of universal access to medical care." Dissent at 3249. We would be inclined to agree that the country's refusal to provide universal health care, and the concomitant suffering so many Americans are forced to undergo, demonstrates a serious flaw in our national values. One answer, of course, is that concerns over the absence of decent medical coverage in this country should be addressed to Congress, which, if it recognizes the values the dissenters and others espouse, will surely enact the sorely-needed, health-care legislation it has up to now rejected. As members of the judicial branch, however, we are compelled to stand aside from that battle. On the other hand, we are certainly not obligated to pile injury upon injury by holding that all of our citizens may be subjected to the prospect of needless pain, suffering, and degradation at the end of their lives, either because of our concern over Congress' failure to provide government-insured health care or alternatively in order to satisfy the moral or religious precepts of a portion of the population.

c.

We are also aware of the concern that doctors become hardened to the inevitability of death and to the plight of terminally ill patients, and that they will treat requests to die in a routine and impersonal manner, rather than affording the careful, thorough, individualized attention that each request deserves. The day of the family doctor who made house calls and knew the frailties and strengths of each family member is long gone. So, too, in the main, is the intense personal interest that doctors used to take in their patients' welfare and activities. Doctors like the rest of society face constantly increasing pressures, and may not

always have the patience to deal with the elderly, some of whom can be both difficult and troublesome. Nevertheless, there are many doctors who specialize in geriatric care and there are many more who are not specialists but who treat elderly patients with great compassion and sensitivity. We believe that most, if not all, doctors would not assist a terminally ill patient to hasten his death as long as there were any reasonable chance of alleviating the patient's suffering or enabling him to live under tolerable conditions. We also believe that physicians would not assist a patient to end his life if there were any significant doubt about the patient's true wishes. To do so would be contrary to the physicians' fundamental training, their conservative nature, and the ethics of their profession. In any case, since doctors are highly-regulated professionals, it should not be difficult for the state or the profession itself to establish rules and procedures that will ensure that the occasional negligent or careless recommendation by a licensed physician will not result in an uninformed or erroneous decision by the patient or his family.

Having said all this, we do not dismiss the legitimate concerns that exist regarding undue influence. While steps can be taken to minimize the danger substantially, the concerns cannot be wholly eliminated. Accordingly, they are of more than minimal weight and, in balancing the competing interests, we treat them seriously.

4. Effect on Children, Other Family Members, and Loved Ones

[18] The state clearly has a legitimate interest in safeguarding the interests of innocent third parties such as minor children and other family members dependent on persons who wish to commit suicide. That state interest, however, is of almost negligible weight when the patient is terminally ill and his death is imminent and inevitable.

The state cannot help a minor child or any other innocent third party by forcing a terminally ill patient to die a more protracted and painful death. In fact, witnessing a loved one suffer a slow and agonizing death as a result of state compulsion is more likely to harm than further the interests of innocent third parties.[100]

5. Protecting the Integrity of the Medical Profession

[19] The state has a legitimate interest in assuring the integrity of the medical profession, an interest that includes prohibiting physicians from engaging in conduct that is at odds with their role as healers.[101] We do not believe that the integrity of the medical profession would be threatened in any way by the vindication of the liberty interest at issue here. Rather, it is the existence of a statute that criminalizes the provision of medical assistance to patients in need that could create conflicts with the doctors' professional obligations and make covert criminals out of honorable, dedicated, and compassionate individuals.

The assertion that the legalization of physician-assisted suicide will erode the commitment of doctors to help their patients rests both on an ignorance of what numbers of

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[100] According to its protocol, Compassion In Dying will not assist terminally ill patients unless the patient has obtained the approval of family members or others with whom the patient has a close personal relationship. While we do not reach Compassion In Dying's claim or consider the merits of the safeguards it has devised, we note that a similar requirement by the state would raise constitutional concerns. We in no way suggest, however, that a private organization is not free to adopt higher standards than the state is permitted to impose in order to advance its interests or those of its clients.

[101] *Cf. Middlesex County Ethics Committee v. Gasrden*, 457 U.S. 423, 434 (1982) (noting that state has important interest in "maintaining and assuring the professional conduct of professional attorneys it licenses").

doctors have been doing for a considerable time and on a misunderstanding of the proper function of a physician. As we have previously noted, doctors have been discreetly helping terminally ill patients hasten their deaths for decades and probably centuries, while acknowledging privately that there was no other medical purpose to their actions. They have done so with the tacit approval of a substantial percentage of both the public and the medical profession, and without in any way diluting their commitment to their patients.

In addition, as we also noted earlier, doctors may now openly take actions that will result in the deaths of their patients. They may terminate life-support systems, withdraw life-sustaining gastronomy tubes, otherwise terminate or withhold all other forms of medical treatment, and, may even administer lethal doses of drugs with full knowledge of their "double effect."[102] Given the

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[102] The American Medical Association devotes a considerable portion of the amicus brief it filed in this case to arguing that doctors who give medication with knowledge that it will have a double effect, including hastening death, should not be deemed to have violated Washington's assisted suicide law. The organization struggles mightily, albeit unsuccessfully, to distinguish for legal purposes between the administration of medication for a dual and a single effect. Nevertheless, we agree with the AMA's point — the administration of dual effect medication, with informed consent, does not constitute a criminal act. However, if, as the AMA contends, *administering* medicine that will result in death is lawful, we cannot comprehend the logic of its equivocal conclusion that *prescribing* life-ending medication for the patient at his request can constitute a crime, at least "at this time." (If the patient's consent has not been obtained for dual effect treatment, there would of course be even less justification for the AMA's fallacious distinction.) The line the AMA seeks to draw conflicts with reason as well as with the proper constitutional approach. The key factor in both dual effect and physician-assisted suicide cases is that it is the terminally ill patient's voluntary and informed wish that the

similarity between what doctors are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession. This is a conclusion that is shared by a growing number of doctors who openly support physician-assisted suicide and proclaim it to be fully compatible with the physicians' calling and with their commitment and obligation to help the sick.[103] Many more doctors support physician-assisted suicide but without openly advocating a change in the legal treatment of the practice. A recent study of Oregon physicians found that 60% of those who responded believed that physician-assisted suicide should be legal.[104] A recent study of attitudes among physicians in Michigan,

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doctor assist him to die through medical treatment. Were we to agree with those who would label some of the current medical practices engaged in at life's end as killing a patient or "euthanasia," we would put the AMA-sanctioned dual effect practice on that side of the line long before we would include the act of prescribing medication that is to be self-administered. It is the glaring inconsistency in the AMA's position that is undoubtedly responsible in part for the dissent's rejection of the AMA's plea to hold lawful the "dual effect" practice. *See* Dissent at 3223.

[103] For a recent example, see Francis Moore, M.D., Easing Life's End: Doctors, Patients and the Final Medical Dilemma, Harv. Mag. at 46, 47 Aug. 1995 ("It is my credo that assisting people to leave the dwelling place of their body when it is no longer habitable is becoming an obligation of the medical profession").

The Oregon AMA refrained from taking a position on a successful ballot initiative to legalize physician assisted suicide because its membership was sharply divided on whether to back or oppose the measure. Melinda A. Lee & Susan W. Tolle, *Oregon's Assisted Suicide Vote: the Silver Lining*, 124 Annals of Internal Med. 267 (1996).

[104] Melinda Lee, et al., *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 New Eng. J. Med. 310 (1996).

where the state legislature adopted a law banning assisted-suicide as a result of Dr. Jack Kevorkian's activities, found that only 17.2% of the physicians who responded favored a law prohibiting assisted-suicide. Almost all the rest supported one of three options: legalizing physician-assisted suicide (38.9%); permitting the medical profession to regulate the practice (16.1%); or leaving decisions about physician-assisted suicide to the doctor-patient relationship (16.6%).[105] Thus over 70% of the Michigan doctors answering the poll appear to believe that professional ethics do not preclude doctors from engaging in acts that today are classified as "assisted suicide." Even among those doctors who oppose assisted suicide medical ethics do not lie at the heart of the objections. The "most important personal characteristic" separating those doctors from their colleagues is a strong religious identification.[106]

Whether or not a patient can be cured, the doctor has an obligation to attempt to alleviate his pain and suffering. If it is impossible to cure the patient or retard the advance of his disease, then the doctor's primary duty is to make the patient as comfortable as possible. When performing that task, the doctor is performing a proper medical function, even though he knows that his patient's death is a necessary and inevitable consequence of his actions.[107]

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[105] Jerald G. Bachman, *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 New Eng. J. Med. 303, 305 fig. 1 (1996).

[106] *Id.* at 308.

[107] The state also has an interest in furthering the progress of medical science. Some argue that the relentless search for new and better treatments for the terminally ill might be undermined by permitting physicians to help terminally ill patients hasten their deaths. We put no stock in this argument. As is shown by the experience of countless patients suffering from cancer and AIDS, most patients are

As noted earlier, the American Medical Association filed an amicus brief urging that we uphold the practice of administering medicine with a dual effect. At the same time, it takes the position that physician-assisted suicide should not be legalized, at least as of this time.[108] Twenty years ago, the AMA contended that performing abortions violated the Hippocratic Oath; today, it claims that assisting terminally ill patients to hasten their death does likewise. Clearly, the Hippocratic Oath can have no greater import in deciding the constitutionality of physician assisted-suicide than it did in determining whether women had a constitutional right to have an abortion. In *Roe*, the Court cited a scholar's conclusion that the Hippocratic Oath "originated in a group representing only a small segment of Greek opinion and that it certainly was not accepted by all ancient physicians." The Court stressed the Oath's "rigidity" and was not deterred by its prohibitory language regarding abortion.[109] As *Roe* shows, a literalist reading

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not willing to give up hope until they have exhausted all possibilities provided by established treatments and in addition have tried any available experimental ones. We are certain that there will be neither a shortage of patients willing to volunteer for controlled studies of new medications and treatments nor of researchers equally willing to develop new forms and manners of treatment.

[108] In its amicus brief in this case, the AMA attached a Journal of American Medicine article, reporting the conclusion of the AMA's Council on Ethical and Judicial Affairs. The article concluded this way: "the societal risk of involving physicians in medical interventions to cause patients' death is too great in this culture to condone euthanasia or physician-assisted suicide *at this time*" (emphasis added).

[109] In one of the two translations quoted by the *Roe* Court, the Oath says:

> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give a woman an abortive remedy.

Roe, 410 U.S. 131.

of the Hippocratic Oath does not represent the best or final word on medical or legal controversies today.[110] Were we to adhere to the rigid language of the oath, not only would doctors be barred from performing abortions or helping terminally ill patients hasten their deaths, but according to a once-accepted interpretation, they would also be prohibited from performing any type of surgery at all,[111] a position that would now be recognized as preposterous by even the most tradition-bound AMA members. More important, regardless of the AMA or its position, experience shows that most doctors can readily adapt to a changing legal climate. Once the Court held that a woman has a constitutional right to have an abortion, doctors began performing abortions routinely and the ethical integrity of the medical profession remained undiminished. Similarly, following the recognition of a constitutional right to assisted suicide, we believe that doctors would engage in the permitted practice when appropriate, and that the integrity of the medical profession would survive without blemish.

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[110] We note that even in ancient times many physicians did not interpret the oath literally. As three commentators said, "It is well established that Greek and Roman physicians, even those who were Hippocratic, often supplied their patients with the means to commit suicide, despite the injunction against assistance in suicide embodied in the Hippocratic oath." Rebecca C. Morgan et al., The Issue of Personal Choice: The Competent Incurable Patient and the Right to Commit Suicide, 57 Missouri L. Rev. 3, 46 (1992).

[111] Peter A. Ubel, *Assisted Suicide and the Case of Dr. Quill and Diane*, 8 Issues In Law & Med. 487, 497 (1993).

Recognizing the right to "assisted-suicide" would not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience. Those doctors who believe that terminally ill, competent, adult patients should be permitted to choose the time and manner of their death would be able to help them do so. We believe that extending a choice to doctors as well as to patients would help protect the integrity of the medical profession without compromising the rights or principles of individual doctors and without sacrificing the welfare of their patients.[112]

6. Fear of Adverse Consequences

We now consider the state's final concern. Those opposed to permitting physician-assisted suicide often point to a concern that could be subsumed under the state's general interest in preserving life, but which for clarity's sake we treat separately. The argument is a purely pragmatic one that causes many people deep concern: permitting physician-assisted suicide would "open Pandora's Box."[113]

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[112] Patients who are concerned about the possibility that they will suffer an unwanted agonizing death because of a doctor's unwillingness to provide them with the medication they need would have the opportunity to select a doctor whose view of the physician's role comports with theirs. See Michigan Commission on Death and Dying, Final Report (June 1994), which reprints Model Statute Supporting Aid-In-Dying, including § 1.11, providing mechanism for the transfer of patients in case a physician refuses to provide aid-in-dying.

[113] *See generally* Yale Kamisar, *When Is there A Constitutional "Right To Die"? When Is There No Constitutional Right to Live"?* 25 Geo. L. Rev. 1203 (1991).

Once we recognize a liberty interest in hastening one's death, the argument goes, that interest will sweep away all restrictions in its wake. It will only be a matter of time, the argument continues, before courts will sanction putting people to death, not because they are desperately ill and want to die, but because they are deemed to pose an unjustifiable burden on society.[114] Known as a slippery slope argument or what one commentator has called the "thin edge of the wedge" argument,[115] the opponents of assisted-suicide conjure up a parade of horribles and insist that the only way to halt the downward spiral is to stop it before it starts. *See Compassion In Dying*, 49 F.3d at 590-91 (providing list of horribles).

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[114] The dissent cites the experience in the Netherlands, where physician-aid-in-dying is allowed in some circumstances, to buttress both its claims that physician-assisted suicide cannot be adequately regulated and that approval of that limited practice will inevitably lead to the administration of death-inducing drugs without the patient's consent. Dissent at 3250, 3259. We note that the reports on relevant medical practices in the Netherlands are so mixed that it is difficult to draw any conclusions from them. *See, e.g.*, Maurice A.M., de Wachter, *Euthanasia in the Netherlands; Dying Well? A Colloquy on Euthanasia and Assisted Suicide*, The Hastings Center Report (1992) (describing sharply divergent appraisals of Dutch practices). We also note, that even if it were clear what lessons to draw from the Dutch experience, it would be far from clear how to apply those lessons to the United States. As two commentators have said: "One must be wary, however, of inferences drawn from the Netherlands and applied to the United States. Cultural, legal, psychological, and other variables make generalizations problematic, even in the Netherlands itself." T. Howard Stone & William J. Winslade, *Physician-Assisted Suicide and Euthanasia in the United States*, 16 J. Legal. Med. 481 (1995).

[115] Eugenie Anne Gifford, *Artes Moriendi: Active Euthanasia and the Art of Dying*, 40 UCLA L. Rev. 1545, 1566 (1993), citing Glanville Williams.

This same nihilistic argument can be offered against any constitutionally-protected right or interest. Both before and after women were found to have a right to have an abortion, critics contended that legalizing that medical procedure would lead to its widespread use as a substitute for other forms of birth control or as a means of racial genocide. Inflammatory contentions regarding ways in which the recognition of the right would lead to the ruination of the country did not, however, deter the Supreme Court from first recognizing and then two decades later reaffirming a constitutionally-protected liberty interest in terminating an unwanted pregnancy. In fact, the Court has *never* refused to recognize a substantive due process liberty right or interest merely because there were difficulties in determining when and how to limit its exercise or because others might someday attempt to use it improperly.

[20] Recognition of any right creates the possibility of abuse. The slippery slope fears of *Roe*'s opponents have, of course, not materialized. The legalization of abortion has not undermined our commitment to life generally; nor, as some predicted, has it led to widespread infanticide. Similarly, there is no reason to believe that legalizing assisted suicide will lead to the horrific consequences its opponents suggest.

[21] The slippery slope argument also comes in a second and closely related form. This version of the argument states that a due process interest in hastening one's death, even if the exercise of that interest is initially limited to the terminally ill, will prove infinitely expansive because it will be impossible to define the term "terminally ill." *See Compassion In Dying*, 49 F.3d at 593. (After all, all of us are terminal in some sense of the word, are we not?). *See id*. The argument rests on two false premises. First it presupposes a need for greater precision than is required in

constitutional law.[116] Second, it assumes that the terms "terminal illness" or "terminal condition" cannot be defined, even though those terms have in fact been defined repeatedly. They have, for example, been defined in a model statute, The Uniform Rights of the Terminally Ill Act,[117] and in more than 40 state natural death statutes,[118] including Washington's. The model statute and some of the state statutes have defined the term without reference to a fixed time period; others have taken the opposite approach, defining terminal to mean that death is likely to ensue within six months. As we have noted earlier, the Washington Act, like some others, includes persons who are permanently unconscious, that is in an irreversible coma or a persistent vegetative state. RCW 70.122.020(6). While defining the term "terminally ill" is not free from difficulty, the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined. Indeed, all of the persons described in the various statutes would appear to fall within an appropriate definition of the term. In any event, it is apparent that purported definitional difficulties that have repeatedly been surmounted provide no legitimate reason for refusing to recognize a liberty interest in hastening one's death.

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[116] *See, e.g., United States v. Vuitch*, 402 U.S. 62, 71-72 (1971) (holding that an abortion statute barring abortions not performed to protect the mother's *health* was not unconstitutionally vague).

[117] 9B U.L.A. 96, 98 (Supp. 1992). According to the model act, a patient is in a terminal condition if the medical condition is incurable and irreversible, that is, without administering life-sustaining treatment the condition, will, in the opinion of the attending physician, result in death in a relatively short time. Alan Meisel, *The Right to Die: 1994 Cumulative Supplement No. 2* 366 (1994).

[118] *See* statutes cited *supra* note 77.

We do not dispute the dissent's contention that the prescription of lethal medication by physicians for use by terminally ill patients who wish to die does not constitute a clear point of demarcation between permissible and impermissible medical conduct. We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them.[119] The question whether that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one. We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. In the first case -- volitional death -- the physician is aiding or assisting a patient who wishes to exercise a liberty interest, and in the other -- involuntary death -- another person acting on his own behalf, or, in some instances society's, is determining that an individual's life should no longer continue.[120] We consider it less important who

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[119] When the physician rather than the patient administers the drug, the act is ordinarily classified as physician-aid-in-dying.

[120] In the latter case, "involuntary death," when the motive is benign or altruistic, we classify the act as "euthanasia." There is, however, no universally accepted meaning for that term. Some commentators distinguish between active and passive euthanasia, for example, while others do not. We define euthanasia as the act or practice of painlessly putting to death persons suffering from incurable and distressing disease, as an act of mercy, but *not* at the person's request. The issue of euthanasia is not implicated here. While we place euthanasia, as we define it, on the opposite side of the constitutional line we draw for purposes of this case, we do not intimate any view as to the constitutional or legal implications of the practice. Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.

administers the medication than who determines whether the terminally ill person's life shall end. In any event, here we decide only the issue before us -- the constitutionality of prohibiting doctors from prescribing medication for use by terminally ill patients who wish to hasten their death.

B.

The Means by Which the State Furthers Its Interests

In applying the balancing test, we must take into account not only the strength of the state's interests but also the means by which the state has chosen to further those interests.

1. Prohibition — A Total Ban for the Terminally Ill

[22] Washington's statute prohibiting assisted suicide has a drastic impact on the terminally ill. By prohibiting physician assistance, it bars what for many terminally ill patients is the only palatable, and only practical, way to end their lives. Physically frail, confined to wheelchairs or beds, many terminally ill patients do not have the means or ability to kill themselves in the multitude of ways that healthy individuals can. Often, for example, they cannot even secure the medication or devices they would need to carry out their wishes.

Some terminally ill patients stockpile prescription medicine, which they can use to end their lives when they decide the time is right. The successful use of the

stockpile technique generally depends, however, on the assistance of a physician, whether tacit or unknowing (although it is *possible* to end one's life with over-the-counter medication). Even if the terminally ill patients are able to accumulate sufficient drugs, given the pain killers and other medication they are taking, most of them would lack the knowledge to determine what dose of any given drug or drugs they must take, or in what combination. Miscalculation can be tragic. It can lead to an even more painful and lingering death. Alternatively, if the medication reduces respiration enough to restrict the flow of oxygen to the brain but not enough to cause death, it can result in the patient's falling into a comatose or vegetative state.

[23] Thus for many terminally ill patients, the Washington statute is effectively a prohibition. While technically it only prohibits one means of exercising a liberty interest, practically it prohibits the exercise of that interest as effectively as prohibiting doctors from performing abortions prevented women from having abortions in the days before *Roe*.[121]

2. Regulation — A Permissible Means of Promoting State Interests

[24] State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests. Any of several model statutes might serve as an

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[121] *See also Carey v. Population Services International*, 431 U.S. 678 (1977). Building on its decision in *Griswold* that the state could not ban the sale of contraceptives, the Court held in *Carey*, that the state could not prohibit adults from securing contraceptives through the most readily available channels by prohibiting everyone but licensed pharmacists from distributing them.

example of how these legitimate and important concerns can be addressed effectively.[122]

[25] By adopting appropriate, reasonable, and properly drawn safeguards Washington could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all of the requisite standards. Without endorsing the constitutionality of any particular procedural safeguards, we note that the state might, for example, require: witnesses to ensure voluntariness; reasonable, though short, waiting periods to prevent rash decisions; second medical opinions to confirm a patient's terminal status and also to confirm that the patient has been receiving proper treatment, including adequate comfort care; psychological examinations to ensure that the patient is not suffering from momentary or treatable depression; reporting procedures that will aid in the avoidance of abuse. Alternatively, such safeguards could be adopted by interested medical associations and other organizations involved in the provision of health care, so long as they meet the state's needs and concerns.[123]

While there is always room for error in any human endeavor, we believe that sufficient protections can and will be developed by the various states, with the assistance of the medical profession and health care industry, to

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[122] *See*, for instance, the procedural safeguards included in Oregon's Death With Dignity Act, described in Lee, *supra* note 104, or the Michigan Model Statute Supporting Aid-In-Dying, appended to the Final Report of the Michigan Commission on Death and Dying, *supra*, note 84.

[123] We do not suggest that all of these safeguards are either necessary or desirable singularly or collectively. That is essentially a matter for the states to determine. In doing so, they would of course consider the practical implications of the various potential procedural safeguards before deciding which, if any, to adopt.

ensure that the possibility of error will be remote. We do not expect that, in this nation, the development of appropriate statutes and regulations will be taken lightly by any of the interested parties, or that those charged with their enforcement will fail to perform their duties properly.

In treating a prohibition differently from a regulation, we are following the approach that the Court took in the only right-to-die case to come before it. In *Cruzan*, the Court recognized that the states had a legitimate role to play in regulating the process of refusing or terminating life-sustaining medical treatment even if they could not prohibit the making of decisions that met applicable state standards. The Court explicitly recognized that states did not have to refrain from acting, but rather could adopt appropriate regulations to further their legitimate interests. Missouri's requirement for clear and convincing evidence of a patient's wishes was a regulation designed to reduce the risk of erroneous decisions. The Court upheld that regulation, a requirement that, of course, had far less impact on the exercise of the due process liberty interest than the de facto prohibition at issue here.

To those who argue that courts should refrain from declaring that the terminally ill have a constitutional right to physician-assisted suicide and that we should leave such matters to the individual states, we reply that where important liberty interests are at stake it is not the proper role of the state to adopt statutes totally prohibiting their exercise. Rather, the state should enact regulatory measures that ensure that the exercise of those interests is properly circumscribed and that all necessary safeguards have been provided. In the case of abortions and in the case of the withdrawal of life-sustaining medical treatment, the Court permitted states to enact appropriate regulations that would further its legitimate interests. In this case, like the others, the guiding principle is found in the words of

Justice O'Connor. "[T]he more challenging task of crafting appropriate procedures for safeguarding . . . [terminally ill patients'] liberty interests is entrusted to the 'laboratory' of the states in the first instance." *Cruzan*, 497 U.S. at 287, 292 (O'Connor, J., concurring) (internal citation omitted).[124]

C.

The Strength of the Liberty Interest

Earlier in the opinion we described the liberty interest at issue here and explained its importance. We also explained that the strength of that interest is dependent on a number of factors, especially the individual's physical condition. We noted that an individual's liberty interest in hastening his death is at its low point when that person is young and healthy, because forcing a robust individual to continue living does not, at least absent extraordinary

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[124] For an opposing view, see Posner, *supra* note 87, at 260-61. Posner argues that while laws banning assisted suicide (as applied to the terminally ill) violate Millsian principles and should, as a matter of policy, be repealed, the decision as to whether to do so should be made at the state level by voters and legislators. His reasoning for leaving the question to the states is based in part on his belief that moral values are sometimes coterminous with state boundaries, and that a national rule would be premature. He uses as an example the case of abortion, suggesting that *Roe v. Wade* wrongfully preempted the ability of individual states to resolve that issue properly.

One problem with allowing each state to decide whether to *prohibit* the exercise of a liberty interest is the human suffering that results from a patchwork-quilt pattern of prohibitory legislation. Permitting assisted suicide in one state but prohibiting it in a neighboring one can easily lead to entangled legal battles in which the dying patient or his family tries to obtain approval for his transfer to the more permissive state. The unseemly legal struggle that ensues turns out all too often to have been academic, since by the time the matter is resolved, the patient has suffered the distressing fate he sought to avoid.

circumstances, subject him to "pain . . . [and] suffering that is too intimate and personal for the State to insist on . . . ." *Casey*, 112 S. Ct. at 2807. As we also made clear, when a mentally competent adult is terminally ill, and wishes, free of any coercion, to hasten his death because his remaining days are an unmitigated torture, that person's liberty interest is at its height. For such a person, being forced to live is indeed being subjected to "pain . . . [and] suffering that is too intimate and personal for the State to insist on . . . ." *Id.*

D.

The Burden on the Liberty Interest

We have also previously discussed at some length the nature and extent of the burden that the Washington statute imposes on the liberty interest. Here, we need only mention some of the specific evidence introduced by the plaintiffs and refer to some of our earlier analysis. The plaintiffs offered considerable specific testimony involving individual patients that strongly supports their claims that the Washington statute frequently presents an insuperable obstacle to terminally ill persons who wish to hasten their deaths by peaceful means. The testimony produced by the plaintiffs shows that many terminally ill patients who wish to die with dignity are forced to resort to gruesome alternatives because of the unavailability of physician assistance. One such patient, a 34-year-old man dying from AIDS and lymphoma, asked his physician for drugs to hasten his inevitable death after enduring four excruciatingly painful months because he did not wish to die in a hospital in a drug-induced stupor. His doctor, Dr. Harold Glucksberg, one of the physician plaintiffs in this case, refused because he feared prosecution under Washington Statute RCW 9A.36.060. Denied medical assistance, the patient ended his life by jumping from the

West Seattle bridge and plummeting to his death.[125] Fortunately, he did not survive the plunge and require permanent hospitalization in an even more exacerbated state of pain.

Deprived of physician assistance, another terminally ill patient took his own life by withholding his insulin and letting himself die of insulin shock.[126] Like many terminally ill patients, one individual killed himself in a secretive and lonely fashion, in order to spare his family from possible criminal charges; as a result he was deprived of a chance to die in a dignified manner with his loved ones at his side. The man's daughter described her father's death this way:

> When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12 gauge shot gun. He was 84. . . My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.[127]

The plaintiffs also produced testimony showing that some terminally ill patients who try to kill themselves are unsuccessful, maiming instead of killing themselves, or that they succeed only after subjecting themselves to needless, excruciating pain.[128] One such terminally ill patient, a mentally competent woman in her 80s suffering from

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[125] *Compassion In Dying*, 850 F. Supp. at 1458, and Declaration of Harold Glucksberg, M.D., at 5-6.

[126] Brief of Amicus Curiae on Ten Surviving Family Members in Support of Physician-Assisted "Suicide" at 4-5.

[127] *Id.* at 7.

[128] *See* Declaration of John P. Geyman, M.D., ER at 205-206.

metastatic breast cancer, sought medication to hasten her death from her primary care physician, Dr. Abigail Halperin, one of the physician plaintiffs in this case. Although Dr. Halperin believed, in her professional judgment, that she should accommodate her patient's wishes, she did not do so because she feared prosecution under Washington statute RCW 9A.36.060. The patient acted on her own to hasten her death by placing a plastic bag over her head, securing it so no more air could enter. She suffocated to death, an end that was certainly more painful and inhumane than the death she would have experienced had she been given the prescriptions she sought.[129]

Next, the plaintiffs produced testimony showing that many terminally ill patients are physically or psychologically unable to take their lives by the violent means that are almost always their only alternatives in the absence of assistance from a physician. One man declared that his terminally ill wife "wanted to die but we did not know how to do it. We could not ask her doctors. . . She feared over-the-counter pills, hearing of all the cases where the person woke up a vegetable. Carbon monoxide was out since she wanted the dignity of dying in her own bed, surrounded by the things she loved."[130] Another woman told how her father, "to whom dignity was very important, lay dying, diapered, moaning in pain, begging to die."[131]

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[129] *Compassion In Dying*, 850 F. Supp. at 1458, and Declaration of Abigail Halperin, M.D., at 4-5.

[130] Brief of Amicus Curia of Ten Surviving Family Members in Support of Physician-Assisted "Suicide" at 6.

[131] *Id.*

[26] Following the approach of the Court in *Casey*, 112 S. Ct. at 2828, we note that there is also an extensive body of legal,[132] medical,[133] and sociological literature,[134] lending support to the conclusion that a prohibition on physician assistance imposes an onerous burden on terminally ill, competent adults who wish to hasten their deaths. That conclusion is further buttressed by extensive anecdotal evidence compiled in newspapers[135] and

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[132] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, And Individual Freedom* 179-217 "Dying And Living") (1993); Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, Hastings Center Rep. 676 (1993).

[133] Lonny Shavelson, M.D., *A Chosen Death: The Dying Confront Assisted Suicide* (1995); Timothy E. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* 98-120 ("Limitations of comfort Care") (1993); Franklin G. Miller, et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Howard Brody, *Assisted Death: A Compassionate Response to Medical Failure*, 327 N. Engl. J. Med. 1384 (1992).

[134] Russel D. Ogden, *Euthanasia, Assisted Suicide & AIDS* (1994).

Derek Humphrey's *Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying*, which shot to the top of the New York Times best seller list for 18 weeks when it was released in 1991, provides graphic practical advice for how terminally ill patients can kill themselves and for how family members can assist them. Chapter titles include the following: Bizarre Ways to Die, Self Starvation, Storing Drugs, and Self-Deliverance Via the Plastic Bag.

[135] In North Carolina, for example, an elderly woman helped her 81-year-old sister, who had a painful, degenerative heart condition, kill herself after her sister begged repeatedly for assistance in ending her life. The woman "hooked vacuum cleaner hose to the end of the exhaust pipe of the family car, gave her sister the other end of the hose, said good-bye, and left, closing the garage door." Shaffer at 360 n. 79.

magazines.[136] Although the statute at issue does not totally prohibit the exercise of the liberty interest by all who possess it, it does effectively prohibit its exercise by almost all of the terminally ill. In fact, as applied, the ban on the liberty interest is close to complete; for, there are few terminally ill persons who do not obtain illicit help from someone in the course of their efforts to hasten their deaths.

There is an additional burden on loved ones and family members that is often overlooked. Some terminally ill persons enlist their children, parents, or others who care for them deeply, in an agonizing, brutal and damaging endeavor, criminalized by the state, to end their pain and suffering. The loving and dedicated persons who agree to help -- even if they are fortunate enough to avoid prosecution, and almost all are -- will likely suffer pain and guilt for the rest of their lives. Those who decline to

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A 67-year-old retired engineer helped his wife of 42 years who was suffering from cancer to commit suicide by preparing an overdose of sedatives, sitting with her as she took them, and then helping place a plastic bag over her head. Under Florida statutes, the man faced a 15-year maximum penalty. *Id.* at n. 79.

See also Dudley Clendinen, When Death is a Blessing and Life Is Not, N.Y. Times, at A15, Feb. 5, 1996; Clyde H. Farnsworth, Bungled AIDS Suicides Often Increase the Suffering, N.Y. Times, June 14, 1994, at B9; Clyde H. Farnsworth, Woman Who Lost a Right-to-Die Case in Canada Commits Suicide, N.Y. Times, Feb. 15, 1994, at A13; AP, Right to Die Fails; Rancher Kills Self, St. Petersburg Times, Nov. 22, 1991, at A8 (describing a California man suffering from leukemia and diabetes who arranged to end his life with help from his physician but killed himself with a shotgun blast to his head after a California initiative legalizing assisted suicide failed at the polls).

[136] Andrew Solomon, A Death of One's Own, The New Yorker, May 22, 1995, at 54; Lisa Belkin, There's No Simple Suicide, N.Y. Times Mag., Nov. 14, 1992, § 6 at 48-55, 63, 74-75.

assist may always wonder whether they should have tried to save their parent or mate from enduring, unnecessary and protracted agony. This burden would be substantially alleviated if doctors were authorized to assist terminally ill persons to end their lives and to supervise and direct others in the implementation of that process.

E. The Consequences of Upholding or Overturning the Statutory Provision

In various earlier sections of this opinion, we have discussed most of the consequences of upholding or overturning the Washington statutory provision at issue, because in this case those consequences are best considered as part of the discussion of the specific factors or interests. The one remaining consequence of significance is easy to identify: Whatever the outcome here, a host of painful and agonizing issues involving the right to die will continue to confront the courts. More important, these problems will continue to plague growing numbers of Americans of advanced age as well as their families, dependents, and loved ones. The issue is truly one which deserves the most thorough, careful, and objective attention from all segments of society.

VI.

Application of the Balancing Test and Holding

Weighing and then balancing a constitutionally-protected interest against the state's countervailing interests, while bearing in mind the various consequences of the decision, is quintessentially a judicial role. Despite all of the efforts of generations of courts to categorize and objectify, to create multi-part tests and identify weights to be attached to the various factors, in the end balancing entails the exercise of judicial judgment rather than the application of scientific or mathematical formulae. No legislative body can perform the task for us. Nor can any computer. In

the end, mindful of our constitutional obligations, including the limitations imposed on us by that document, we must rely on our judgment, guided by the facts and the law as we perceive them.

As we have explained, in this case neither the liberty interest in choosing the time and manner of death nor the state's countervailing interests are static. The magnitude of each depends on objective circumstances and generally varies inversely with the other. The liberty interest in hastening death is at its strongest when the state's interest in protecting life and preventing suicide is at its weakest, and vice-versa.

The liberty interest at issue here is an important one and in, the case of the terminally ill, is at its peak. Conversely, the state interests, while equally important in the abstract, are for the most part at a low point here. We recognize that in the case of life and death decisions the state has a particularly strong interest in avoiding undue influence and other forms of abuse. Here, that concern is ameliorated in large measure because of the mandatory involvement in the decision-making process of physicians, who have a strong bias in favor of preserving life, and because the process itself can be carefully regulated and rigorous safeguards adopted. Under these circumstances, we believe that the possibility of abuse, even when considered along with the other state interests, does not outweigh the liberty interest at issue.

The state has chosen to pursue its interests by means of what for terminally ill patients is effectively a total prohibition, even though its most important interests could be adequately served by a far less burdensome measure. The consequences of rejecting the as-applied challenge would be disastrous for the terminally ill, while the adverse

consequences for the state would be of a far lesser order. This, too, weighs in favor of upholding the liberty interest.

[27] We consider the state's interests in preventing assisted suicide as being different only in degree and not in kind from its interests in prohibiting a number of other medical practices that lead directly to a terminally ill patient's death. Moreover, we do not consider those interests to be significantly greater in the case of assisted suicide than they are in the case of those other medical practices, if indeed they are greater at all. However, even if the difference were one of kind and not degree, our result would be no different. For no matter now much weight we could legitimately afford the state's interest in preventing suicide, that weight, when combined with the weight we give all the other state's interests, is insufficient to outweigh the terminally ill individual's interest in deciding whether to end his agony and suffering by hastening the time of his death with medication prescribed by his physician. The individual's interest in making that vital decision is compelling indeed, for no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end. If broad general state policies can be used to deprive a terminally ill individual of the right to make that choice, it is hard to envision where the exercise of arbitrary and intrusive power by the state can be halted. In this case, the state has wide power to regulate, but it may not ban the exercise of the liberty interest, and that is the practical effect of the program before us. Accordingly, after examining one final legal authority, we hold that the "or aids" provision of Washington statute RCW 9A.36.06 is unconstitutional as applied to terminally ill competent adults who wish to

hasten their deaths with medication prescribed by their physicians.[137]

A.

One Possible Obstacle

The final legal obstacle we examine is an opinion of the District Court of Oregon issued after the panel decision in this case. In *Lee v. State of Oregon*, 891 F. Supp. 1429, 1438 (D. Or. 1995), Chief Judge Hogan held that the Oregon Death With Dignity Act, a voter initiative that permits doctors to prescribe medications for terminally ill patients for use in ending their lives, violates the Equal Protection Clause of the Fourteenth Amendment because it deprives terminally ill persons of a *benefit* that is afforded to the non-terminally ill. The *benefit* that the Oregon District Court thought the terminally ill were being deprived of is an Oregon statutory *prohibition* making it a crime for anyone, including doctors, to assist any person, including terminally ill patients, to end their lives, by providing medical assistance or otherwise. The Oregon District Court's reasoning conflicts squarely with the reasoning of this opinion and with the legal conclusions we have reached. Here, we determine that a statute that prohibits doctors from aiding terminally ill persons to hasten their deaths by providing them with prescription medications unconstitutionally *burdens* the liberty interests of the terminally ill. The benefit we conclude the

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[137] While in balancing the competing interests we employ the approach the Court set forth in *Cruzan*, the outcome would be the same *a fortiori* were we to use the "undue burden" test that the District Court employed. *Compassion In Dying*, 850 F. Supp. at 1462-64. There can be no doubt whatsoever that Washington's ban on assisted suicide places a "substantial obstacle" in the path of terminally ill, competent adults who wish to choose the time and manner of their deaths. *Casey* at 2820.

terminally ill are entitled to receive in this case — the right to physician-assisted suicide — is precisely what Judge Hogan determined to be a *burden* and thus unlawful. In short, *Lee* treats a *burden* as a *benefit* and a *benefit* as a *burden*. In doing so, Judge Hogan clearly erred. *Lee* not only does not aid us in reaching our decision, its reasoning is directly contrary to our holding.[138]

B.

Is There An Equal Protection Violation?

In the case before us, Chief Judge Rothstein struck down the "or aids" provision of the Washington statute as it applies to the terminally ill, not only on due process grounds but also on the ground that it violates the Equal Protection Clause. Because we are convinced that her first reason is correct, we need not consider the second. One constitutional violation is enough to support the judgment that we reach here.[139]

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[138] We note, incidentally, that if *Lee*'s equal protection analysis were correct, we could not examine the as-applied due process violation we examine here, or arrive at the limited holding we do. A ruling in favor of the terminally ill that was not equally applicable to all other persons would, under *Lee*, violate the Equal Protection Clause. Thus *Lee* would require us to determine whether the entire "or aids" provision of the statute is unconstitutional on its face. Because the rationale on which *Lee* was decided was clearly erroneously, we need not undertake that task.

[139] Unlike *Lee*'s highly irregular equal protection holding — that no rational basis exists for a state's allowing the *terminally ill* to receive medical assistance that will enable them to hasten their deaths while preventing the *young and healthy* from receiving similar medical assistance — the equal protection argument relied on by Chief Judge Rothstein is not insubstantial. Judge Rothstein based her equal protection determination on the difference in the statutory treatment afforded 1) those terminally ill persons who are being kept alive through medical treatment (including the use of artificial medical

VII.

Conclusion

We hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause.[140] We recognize that this decision is a most difficult and controversial one, and that it leaves unresolved a large number of equally troublesome issues that will require resolution in the years ahead. We also recognize that other able and dedicated jurists, construing the Constitution as they believe it must be construed, may disagree not only with the result we reach but with our method of constitutional analysis. Given the nature of the judicial process and the complexity of the task of determining the rights and interests comprehended by the Constitution, good faith

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devices) whose deaths can be brought about by the withdrawal of that treatment and 2) those terminally ill people who have no means of accelerating their deaths unless their doctor provides them with medical assistance. She concluded that it was unconstitutional to permit doctors to take actions that would permit the first group of terminally ill persons to die in comfort while preventing doctors from providing such services to the second group.

[140] We would add that those whose services are essential to help the terminally ill patient obtain and take that medication and who act under the supervision or direction of a physician are necessarily covered by our ruling. That includes the pharmacist who fills the prescription; the health care worker who facilitates the process; the family member or loved one who opens the bottle, places the pills in the patient's hand, advises him how many pills to take, and provides the necessary tea, water or other liquids; or the persons who help the patient to his death bed and provide the love and comfort so essential to a peaceful death.

disagreements within the judiciary should not surprise or disturb anyone who follows the development of the law. For these reasons, we express our hope that whatever debate may accompany the future exploration of the issues we have touched on today will be conducted in an objective, rational, and constructive manner that will increase, not diminish, respect for the Constitution.

There is one final point we must emphasize. Some argue strongly that decisions regarding matters affecting life or death should not be made by the courts. Essentially, we agree with that proposition. In this case, by permitting the *individual* to exercise the right to *choose* we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people. We are allowing individuals to make the decisions that so profoundly affect their very existence — and precluding the state from intruding excessively into that critical realm. The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power. Under our constitutional system, neither the state nor the majority of the people in a state can impose its will upon the individual in a matter so highly "central to personal dignity and autonomy," *Casey*, 112 S. Ct. at 2807. Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.

AFFIRMED

BEEZER, Circuit Judge, Dissenting:

Wash. Laws 1975, 1st Ex. Sess., ch. 260, § 9A.36.060 says:

> PROMOTING A SUICIDE ATTEMPT.
>
> (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.
>
> (2) Promoting a suicide attempt is a Class C felony.

This law is codified as RCW 9A.36.060. A Class C felony is punishable by imprisonment of up to five years and a fine of up to $10,000. RCW 9A.20.020(1)(c).

The question is whether Washington's criminal prohibition of promoting a suicide attempt, defined as knowingly causing or aiding another person to attempt suicide, violates the constitutional substantive due process or equal protection rights of mentally competent, terminally ill adults to commit physician-assisted suicide. The district court held the Washington statute unconstitutional and I would reverse.

To succeed in arguing that a statute violates substantive due process, the party challenging the statute must show either: (1) that the statute violates a fundamental right and is not narrowly tailored to serve a compelling state interest, or (2) that the statute violates an ordinary, nonfundamental, liberty interest and does not rationally advance some legitimate governmental purpose. *Reno v. Flores*, 507 U.S. 292, ___, 113 S. Ct. 1439, 1447-1449 (1993). I would hold that the mentally competent, terminally ill adults do not have a fundamental right to physician-assisted suicide, but I would hold that they do have an ordinary, nonfundamental, liberty interest in doing so. I would further hold

that RCW 9A.36.060 rationally advances four legitimate governmental purposes: preserving life, protecting the interests of innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession. Because RCW 9A.36.060 rationally advances these four legitimate governmental purposes, it does not violate plaintiffs' constitutional substantive due process rights.

Likewise, I would hold that RCW 9A.36.060 does not violate plaintiffs' constitutional equal protection rights. Plaintiffs are not similarly situated to patients who wish to refuse or withdraw life-sustaining medical treatment, so an equal protection analysis is not even appropriate. If it were appropriate, I would hold that RCW 9A.36.060 rationally advances four legitimate legislative goals and does not violate plaintiffs' constitutional equal protection rights.

I

It is imperative that I make clear what I mean by physician-assisted suicide. The process should be distinguished definitionally from both euthanasia and the withdrawal or refusal of life-sustaining treatment.

Euthanasia occurs when the physician actually administers the agent which causes death. An example is when a physician injects the patient with a poisonous substance. A gray area between euthanasia and bona fide treatment arises when, for example, a physician administers ever-increasing doses of palliative pain-killing medication, and those doses eventually reach toxic levels.

Life-sustaining treatment is defined in Washington as "any medical means that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. [It does not include treatment] deemed necessary solely to alleviate pain."

RCW 70.122.020(5). A patient has a nonfundamental constitutionally protected liberty-based right to refuse or withdraw life-sustaining treatment, including respirators and artificial nutrition and hydration. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). In Washington, that right is also explicitly guaranteed by the Natural Death Act, RCW 70.122.010 *et seq.*

Physician-assisted suicide encompasses the situation where a physician makes available to a patient the means for that patient intentionally to cause his or her own death. For example, physician-assisted suicide would be the proper description of a process in which a physician, with the intent to assist a patient to commit suicide, prescribes medication which, when taken by the patient in sufficient potency and quantity, is lethal. The prescription may be part of a bona fide treatment, or it may be specifically prescribed as a means by which the patient commits suicide.

In all three sorts of cases, euthanasia, withdrawal of life-sustaining treatment, and physician-assisted suicide, there is a decision that other factors outweigh the patient's continuing to live. Plaintiffs ask us to blur the line between withdrawal of life-sustaining treatment and physician-assisted suicide. At the same time, some proponents of physician-assisted suicide would maintain a conceptual distinction between physician-assisted suicide and euthanasia. Associating physician-assisted suicide with a relatively accepted procedure and dissociating it from an unpalatable one are rhetorically powerful devices, but run counter to U.S. Supreme Court precedent,[1] Washington

[1] *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (assuming the existence of a constitutional right to be free from unwanted life-sustaining medical treatment, but implying the constitutionality of prohibitions of assisted suicide).

State statutory law,[2] medical ethics guidelines of the American Medical Association and the American College of Physicians,[3] and legal reasoning.[4]

The proper place to draw the line is between withdrawing life-sustaining treatment (which is based on the right to be free from unwanted intrusion) and physician-assisted suicide and euthanasia (which implicate the assistance of others in controlling the timing and manner of death). The former is constitutionally protected (under *Cruzan*); the latter are not.

II

There are several jurisdictional and prudential concerns which I consider before addressing the merits of this appeal.

A. Procedural posture

This is an interlocutory appeal from the district court's grant of partial summary judgment in favor of plaintiff

[2] *Compare* RCW 9A.36.060 (prohibiting the promotion of a suicide attempt) *with* RCW 70.122.010 *et seq.* (authorizing people to give directives to withhold or withdraw life-sustaining medical treatment).

[3] American Medical Association, *Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs* 2.20 (withholding or withdrawing life-sustaining medical treatment), 2.21 (euthanasia), 2.211 (physician-assisted suicide). *See also* American College of Physicians, *Ethics Manual*, 117 *Annals of Internal Medicine* (Dec. 1992) (reprinted in **Codes of Professional Responsibility** 237, 252 (Rena A. Gorlin, ed., 3d. ed. 1994)).

[4] *See, e.g.*, Yale Kamisar, "Against Assisted Suicide—Even a Very Limited Form," 72 U. Det. Mercy L. Rev. 735, 757 (forthcoming 1995) ("I share the view of the New York State Task Force on Life and the Law that it is 'this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment.'").

patients and physicians, insofar as the physicians represent the interests of their patients. The partial summary judgment has been certified as final pursuant to Fed. R. Civ. P. 54(b). Plaintiff Compassion in Dying is not a party to this appeal; neither are plaintiff physicians, insofar as they represent their own interests.

Three groups, representing four sets of interests, filed this action in the U.S. District Court for the Western District of Washington, seeking a declaration that RCW 9A.36.060 violates the Due Process and Equal Protection Clauses of the United States Constitution. The groups also sought to enjoin the State of Washington from enforcing the statute.

The first plaintiff is Compassion in Dying, a Washington nonprofit corporation organized to assist mentally competent, terminally ill patients in committing suicide by providing them information, counselling and emotional support. The second group of plaintiffs consisted of three mentally competent, terminally ill patients, litigating under pseudonyms: Jane Roe, John Doe, and James Poe. All three are now dead. The third group consists of four physicians licensed by the State of Washington to practice medicine and surgery (Drs. Glucksberg, Preston, Halperin, and Shalit), representing their own interests and those of their patients. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1457-1458 (W.D. Wash. 1994).

Defendants in this action are the State of Washington ("the State") and Christine Gregoire, the Attorney General of Washington. In suits against the State, the Attorney General is designated by statute as the person to receive service of the summons and complaint and to appear and act as counsel for the State. RCW 4.92.020, 4.92.030.

On cross-motions for summary judgment, the district court granted only the motions of the patients and of the

physicians "insofar as the physicians purport to raise claims on behalf of their terminally ill patients." *Compassion in Dying*, 850 F. Supp. at 1457. It denied the motions of Compassion in Dying, the physicians on behalf of themselves, and the State. The district court also declined to enjoin the State from enforcing the statute. The district court found that the statute violated the patients' equal protection and due process rights.

The State appealed, and a panel of this court filed an opinion reversing the district court. *Compassion in Dying*, 49 F.3d 586 (9th Cir. 1995). A majority of the active judges of this court voted to grant a rehearing en banc. *Compassion in Dying*, 62 F.3d 299 (9th Cir. 1995).

The district court's grant of summary judgment is reviewed de novo. *Warren v. City of Carlsbad*, 58 F.3d 439, 441 (9th Cir. 1995). There are no factual issues in dispute; the only issues are constitutional.

B. Mootness

Because the plaintiff patients have all died, the case is now moot as to them. The only remaining plaintiffs who were parties to the partial summary judgment are the plaintiff physicians, insofar as they represent the interests of their patients.

C. Standing

"[T]o satisfy the 'case' or 'controversy' requirement of Article III of the United States Constitution, a plaintiff must allege a present or immediate injury in fact which is fairly traceable to the challenged action and is likely to be redressed by a favorable court decision." *Board of Natural Resources v. Brown*, 992 F.2d 937, 945 (9th Cir. 1993). The plaintiff physicians assert a sufficient injury in fact to satisfy Article III's standing requirements. *See Craig v. Boren*, 429 U.S. 195 (1976) (liquor store owner had standing to challenge restriction on selling beer with 3.2%

alcohol content to 18-20 year-old males). The physicians' injury is fairly traceable to the challenged statute, and the relief sought will redress their harm.

When one party asserts the rights of another party, there is also a prudential component to standing. This prudential component consists of three factors: "the relationship of the litigant to the person whose rights are being asserted; the ability of the person to advance his own rights; and the impact of the litigation on third party interests." *Caplin & Drysdale Chartered v. United States*, 491 U.S. 617, 623 n.3 (1989). In the abortion context, physicians may assert the rights of their patients.. *Singleton v. Wulff*, 428 U.S. 106 (1976). The same reasoning, regarding *jus tertii* standing based on the physician-patient relationship, applies in this case. In *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994),[5] a case similar to this one, the district court for the Southern District of New York held that physician plaintiffs do have standing to represent the interests of their patients, apparently on the theory that the physicians are in a special relationship with their patients in respects relevant to the alleged right. *Id.* at 82.

III

Plaintiffs' challenge to the Washington statute is "as applied." Challenges to a statute may either be facial or as applied. Justice Scalia concisely summarizes the operation of facial and as applied challenges:

> Statutes are ordinarily challenged, and their constitutionality evaluated, "as applied"—that is, the plaintiff contends that the application of the statute in the particular context in which he has acted, or in which he proposes to act, would be unconstitutional.

[5] The appeal in this case was heard on September 1, 1995 under the name *Quill v. Vacco*, No. 95-7028 (2d Cir.).

> The practical effect of holding a statute unconstitutional "as applied" is to prevent its future application in a similar context but not to render it utterly inoperative. To achieve the latter result, the plaintiff must succeed in challenging the statute "on its face." Our traditional rule has been, however, that a facial challenge must be rejected unless there exists *no set of circumstances* in which the statute can constitutionally be applied. *See, e.g., United States v. Salerno*, 481 U.S. 739, 745, 107 S. Ct. 2095, 2100, 95 L. Ed. 2d 697 (1987).

Ada v. Guam Society of Obstetricians and Gynecologists, 113 S. Ct. 633, 634 (1992) (Scalia, J., dissenting from denial of certiorari). *See also, e.g., Frazier v. Heebe*, 482 U.S. 641, 643 (1986) (petition alleged unconstitutionality of a regulation on its face and as applied); *United States v. James Daniel Good Real Property*, ___ U.S. ___, 114 S. Ct. 492, 513 (1993) (O'Connor, J., concurring in part, dissenting in part) (characterizing the constitutional challenge in that case as "as applied").

The district court characterizes plaintiffs' challenge as "facial." *Compassion in Dying*, 850 F. Supp. at 1459. The district court's characterization is apparently due to the fact that the action is a preenforcement review seeking a declaratory judgment. It has not yet been "applied" to the plaintiffs, in the sense that no party to this action has been prosecuted. This is an incorrect usage of the "facial" and "as applied" distinction.

In *Salerno*, the Supreme Court described what is necessary to succeed in a facial constitutional challenge to a statute:

> A facial challenge to a statute is, of course, the most difficult challenge to mount successfully, since the

> challenger must establish that no set of circumstances exists under which the Act would be valid. The fact that the [statute] might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid, since we have not recognized an "overbreadth" doctrine outside the limited context of the First Amendment.

481 U.S. at 745.

Plaintiffs here do not challenge the applicability and constitutionality of the statute to, for example, prison inmates who incite their coprisoners to suicide. Rather, as the district court states, "Plaintiffs challenge the statute only insofar as it bans physician-assisted suicide by mentally competent, terminally ill adults who knowingly and voluntarily choose to hasten their death." *Compassion in Dying*, 850 F. Supp. at 1456. Because plaintiffs have made no attempt to demonstrate that there is *no* set of circumstances under which the statute would be valid, their challenge cannot be facial under *Salerno*.

Analyzing RCW 9A.36.060, the district court concludes "that the *Casey* 'undue burden' standard, set forth by the Supreme Court five years after *Salerno*, controls in this case." *Compassion in Dying*, 850 F. Supp. at 1462 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, _____, 112 S. Ct. 2791, 2836-2837 (1992) ("*Casey*")). The district court relies on two Court of Appeals cases and a concurrence by Justice O'Connor to support the proposition that *Casey* and *Salerno* conflict with each other. *Id.* at 1463. All of the cases cited by the district court deal with the abortion context.

To date, the Supreme Court has not extended *Casey's* undue burden test beyond abortion cases. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 114 S. Ct. 909, 911 (1994) (Souter, J., in chambers) (describing the undue burden test as "the standard for assessing constitutionality of abortion regulation") ("*Casey II*"). The language of *Casey* supports the proposition that the undue burden test is unique to the abortion right and derived from the right itself. As restated by *Casey*, the essence of the abortion right is "the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State." *Casey*, 112 S. Ct. at 2804.

Since *Casey*, the Court has continued to expressly rely on *Salerno* for facial challenges in non-abortion contexts. *E.g., Anderson v. Edwards*, 115 S. Ct. 1291, 1298-1299 n.6 (1995); *Reno v. Flores*, 113 S. Ct. at 1446.

Applying the *Salerno* analysis to RCW 9A.36.060, the group affected by the statute consists of all people who attempt suicide with someone else's assistance or encouragement. This includes prisoners encouraged by their cellmates, depressed teenagers in suicide pacts, ailing persons of advanced age assisted by their spouses, *and* mentally competent terminally ill adults seeking the assistance of a physician in committing suicide. The group allegedly enjoying constitutional protection consists only of mentally competent, terminally ill adults seeking the assistance of a physician in committing suicide. The entire group affected by the statute is not a subset of those claiming constitutional protection; rather, only a portion of the group affected by the statute overlaps with the group claiming constitutional protection. The inquiry in *Salerno* for the permissibility of a facial challenge is what proportion of the instances of application of the statute will impede constitutional rights. If the answer in the *Salerno* inquiry is less than 100%, then a facial challenge is impermissible.

The challenge of RCW 9A.36.060 cannot be a facial challenge. It is an "as applied" challenge. Because the challenge is "as applied," the fact that there has been no violation of the statute or threatened prosecution for a violation of the statute implicates straightforward ripeness concerns.

IV

The doctrine of ripeness contains two criteria: (1) hardship to parties in delaying resolution of the issues; (2) fitness of issues for judicial resolution. *See Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967). The legal issues are fit for judicial resolution. Waiting for further factual development would require someone to attempt physician-assisted suicide, and for that person's physician to face reasonably foreseeable prosecution under the statute. This is a ripe and justiciable controversy.

It has been suggested that *Poe v. Ullman*, 367 U.S. 497 (1961), might control the ripeness inquiry in this case. *Poe* does not apply here. In *Poe*, the Supreme Court held unripe a challenge by a physician and patients to a Connecticut statute prohibiting the use of contraceptive devices and the giving of medical advice about the use of such devices. The statute had been on the books since 1879, but had been enforced only once in the ensuing eight decades—and that case was a test case in 1940 that was ultimately dismissed. Additionally, contraceptives were "commonly and notoriously" sold in drug stores in Connecticut. Accordingly, the Supreme Court determined that there had been an "undeviating policy of nullification by Connecticut of its anti-contraceptive laws." *Poe*, 367 U.S. at 502. It added, "'Deeply embedded traditional ways of carrying out state policy . . .'—or not carrying it out—'are often tougher and truer law than the dead words of the written text.'" *Id.* (citation omitted). The Court

concluded that there was no "realistic fear of prosecution" and therefore no justiciable controversy ripe for adjudication. *Poe*, 367 U.S. at 508.

Though the history of RCW 9A.36.060 bears some similarities to the statute in *Poe*, the cases may be readily distinguished. In *Poe*, the statute had been on the books for a very long time, and it had never been enforced. And there was more than just a pattern of nonenforcement; the statute was openly and notoriously violated on a regular basis. RCW 9A.36.060 has similarly been on the books, in one form or another, since 1854. But it has been enforced. *E.g., State v. Jamison*, 619 P.2d 352 (Wash. 1980). Further, the factual circumstances in this case are different. First, there is no evidence that the Washington statute is at all "commonly and notoriously" flouted, particularly in the narrow circumstances of physician-assisted suicide for the mentally competent and terminally ill. Second, the issue of physician-assisted suicide as a plausible medical alternative is relatively new. Only since Dr. Kevorkian started assisting patients to commit suicide in Michigan in 1990 has there been significant public and legal attention to the possible differences between physician-assisted suicide and ordinary cases of aiding and abetting suicide. Research indicates at least a dozen prosecutions in states other than Washington of suicide-assisters since 1961.[6] Additionally, there have been a

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[6] Research reveals that suicide-assisters were sometimes charged with involuntary manslaughter, or even murder, rather than with assisting suicide. All the cited cases involve the prosecution of someone else when the decedent actually caused his or her own death. *City of Akron v. Head*, ___ N.E.2d ___, 73 Ohio Misc. 2d 67 (Ohio Mun. 1995); *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995) (holding that Dr. Kevorkian may be prosecuted either under a Michigan statute—held to be constitutional—or under the common-law felony of assisting suicide);

number of murder prosecutions of people who were more actively involved in helping others end their lives (i.e. these defendants actually pulled the trigger or committed similar active steps to cause death).[7]

A limited reading of *Poe* is consistent with intervening Supreme Court precedent. *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289, 302 (1974) ("when fear of criminal prosecution under an allegedly unconstitutional statute is not imaginary or wholly speculative a plaintiff need not 'first expose himself to actual arrest or prosecution to be entitled to challenge [the] statute'" (citation omitted)).

We have construed *Poe* narrowly as well. *San Francisco County Democratic Central Committee v. Eu*, 826 F.2d 814, 821 (9th Cir. 1987), *aff'd*, 489 U.S. 214 (1989) (justiciable controversy exists over constitutionality of never-enforced statute where there is no record that the statute has been commonly and notoriously violated).

People v. Duffy, 185 A.D.2d 371, 586 N.Y.S.2d 150 (N.Y. App. Div. 1992); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991); *People v. Cleaves*, 229 Cal. App. 3d 367, 280 Cal. Rptr. 146 (Cal. App. 1991); *Hinson v. State*, 709 S.W.2d 106 (Ark. App. 1986); *Chanslor v. State*, 697 S.W.2d 393 (Tex. App. 1985); *People v. Campbell*, 335 N.W.2d 27 (Mich. App. 1983); *State v. Marti*, 290 N.W.2d 570 (Iowa 1980); *State v. Bier*, 591 P.2d 1115 (Mont. 1979); *Commonwealth v. Schwartzentruver*, 389 A.2d 181 (Pa. Super. Ct. 1978); *Persampieri v. Commonwealth*, 175 N.E.2d 387 (Mass. 1961).

[7] *Edinburgh v. State*, 896 P.2d 1176 (Okla. Crim. App. 1995); *State v. Sexson*, 869 P.2d 301 (N.M. App.), *cert. denied*, 870 P.2d 753 (M.N. 1994); *Gentry v. State*, 625 N.E.2d 1268 (Ind. App. 1994); *Goodin v. State*, 726 S.W.2d 956 (Tex. App. 1987); *People v. Thomas C.*, 183 Cal. App. 3d 786, 228 Cal. Rptr. 430 (Cal.App. 1986); *Forden v. Joseph G.*, 34 Cal.3d 429, 667 P.2d 1176 (Cal. 1983); *State v. Fuller*, 278 N.W.2d 756 (Neb. 1979).

In short, there are no jurisdictional or prudential concerns which foreclose consideration of the constitutional issues presented by the parties to this appeal.

V

I turn now to an historical account of the role of suicide and assisted suicide in the traditions and consciences of our forbears. Thomas Marzen *et al.* (Marzen) devote over eighty pages to a survey of the attitudes of the "Western Tradition" to suicide. Thomas Marzen *et al.*, "Suicide: A Constitutional Right?" 24 **Duq. L. Rev.** 1, 17-100. The "Western Tradition" has some of its roots in the laws and philosophy of Judeo-Christian groups; however, I am concerned here with the underlying moral and philosophical arguments, and their impact on the historical development of attitudes about suicide.

Here I recount and supplement salient portions of Marzen's account.

Marzen finds only eight instances of suicide in the Old Testament, including the Apocrypha. Seven of the eight instances were cases of ignoble death; the only exception is Samson's destruction of the Philistine temple. Marzen at 18. Marzen speculates that "[t]he infrequency of suicide among the Hebrews . . . was most probably due to their religious creed's positive emphasis on the value of life and the special providence of God." Marzen at 20.

In Plato's philosophy, the ultimate good, aspiration to the realm of the gods and the Forms, is attainable only upon death. However, that death should not be hastened by suicide. Marzen at 21. As Socrates explained, "[I]t probably seems strange to you that it should not be right for those to whom death would be an advantage to benefit themselves . . . [but] we men are put in a sort of guard post, from which one must not release oneself or run away." Plato, *Phaedo* 62a-62b (in Edith Hamilton and

Hungtington Cairns, eds., *Plato: The Collected Dialogues* 44-45, 1987). Plato views suicide as a breach of the relationship between the individual, the state, and the universe. "[W]hen suicide is a rational and deliberate choice, it is deemed to be a flagrant act of contempt for the state and an abandonment of duty to society and the divine order." Marzen at 23-24.

Aristotle echoed Plato's sentiments against suicide:

> To kill oneself to escape from poverty or love or anything else that is distressing is not courageous but rather the act of a coward, because it shows weakness of character to run away from hardships, and the suicide endures death not because it is a fine thing to do but in order to escape from suffering.

Marzen at 24 (quoting Aristotle, *Ethics* Bk. III, ch. 7 (J. Thompson, trans., 1977)).

By contrast, the Stoics endorsed suicide. As Marzen states, "the inevitability of death is the ultimate challenge to liberty . . . [and one must] 'make death [one's] own in order to be free from it.'" Marzen at 25.

Roman law forbade suicide, and introduced the penalty of forfeiture of one's goods and property. Marzen at 26.

Between the decline of the Roman Empire and the rise of the Common Law, ecclesiastical law was a dominant force in the English legal order. *See* Sir Frederick Pollock and Frederic William Maitland, *The History of English Law*, vol. 1, pp. 1-20 (1968).

St. Augustine opposed suicide as violative of the sixth commandment ("Thou shalt not kill."). Marzen at 27. In his *Summa Theologica*, St. Thomas Aquinas stated that

> it is unlawful to kill oneself for three reasons[:] . . . [first], suicide is contrary to the inclination of nature, and to charity whereby every man should love himself[;] . . . [second], every man is part of the community, . . . [and] by killing himself he injures the community[;] . . . [third], because life is God's gift to man, . . . whoever takes his own life, sins against God.

St. Thomas Aquinas, *Summa Theologica*, II-II, q. 64, art. 5, (Fathers of the English Dominican Province, eds., vol. 2, pp. 1465 *et seq.*, 1947). Martin Luther and John Calvin also opposed suicide. Marzen at 31.

In the mid-thirteenth century, Henry de Bracton wrote that a felon committing suicide to escape punishment forfeited all his real property and movable goods, but a person committing suicide "in weariness of life or because he is unwilling to endure further bodily pain . . . may have a successor [of his real property], but his movable goods are confiscated." 2 *Bracton on the Laws of England* 424 (fol. 150) (G. Woodbine ed., S. Thorne trans. 1968). "The principle that suicide of a sane person, for whatever reason, was a punishable felony was thus introduced into English common law." Marzen at 59. In 1644, Sir Edward Coke published his *Third Institute*, in which he treated suicide by a sane person as a form of murder. Marzen at 60-61.

In 1765, Sir William Blackstone condemned suicide in his *Commentaries on the Laws of England*:

> [T]he suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the other temporal, against the king, who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes, making it a peculiar species of felony, a felony committed on one's self.

William Blackstone, 4 *Commentaries* ch. 14, *189.

Among the philosophers who influenced America's founders, John Locke opposed suicide as against natural law and the principle of self-preservation. Marzen at 42.

The American colonies in the seventeenth century generally adopted the English common law criminal prohibitions of suicide. Marzen at 63-66. However, in 1701, William Penn abolished the criminal penalty of forfeiture for suicide, and most of the rest of the colonies (later states) followed suit by the end of the eighteenth century. Marzen at 65-68. Most states have adopted the English common law, to the extent that it does not conflict with state or federal statutory or constitutional requirements. Washington did so in 1862.[8]

Thomas Jefferson opposed criminal prohibitions of suicide, presaging the sentiments of the drafters of the Model Penal Code:

> Men are too much attached to this life to exhibit frequent instances of depriving themselves of it. At any rate, the quasi-punishment of confiscation will not prevent it. For if one can be found who can calmly determine to renounce life, who is so weary of his existence here as rather to make experiment of what is beyond the grave, can we suppose him, in such a state of mind, susceptible to influence from the losses to his family by confiscation? That men in general disapprove of this severity is apparent from the constant practice of juries finding the suicide in

[8] Washington Laws, 1862, p. 83, § 1 provide: "[T]he common law of England, so far as it is not repugnant to, or inconsistent with the constitution and laws of the United States and the organic act, and laws of Washington territory, shall be the rule of decision in all the courts of this territory." This statute was amended to its current form by Washington Laws, 1891, ch. 17, § 1. It is now codified at RCW 4.04.010.

> a state of insanity; because they have no other way of saving the forfeiture.

Marzen at 45 (quoting Thomas Jefferson, 6 *The Papers of Thomas Jefferson* 155 (J.P. Boyd ed. 1952)).

By the turn of the nineteenth century, criminal penalties for suicide appear to have been abandoned in the United States. But the reason for doing so was not a recognition of the supremacy of individual autonomy; rather, it was the desire not to penalize the decedent's family combined with a recognition of the limited deterrent effect of criminal penalties for suicide.

As the nineteenth century progressed, states began to enact criminal prohibitions on assisting suicide. Marzen at 71-74. By 1868, when the Fourteenth Amendment was ratified, twenty-one of the thirty-seven states prohibited assisted suicide by either statute or common law. Marzen at 75. Within the first year of becoming a Territory, Washington enacted a prohibition of assisted suicide.[9] Thirty-six states and territories currently have statutes imposing criminal sanctions for aiding, assisting, causing, or promoting suicide.[10] Three additional states and the

[9] "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter." Terr. Laws 1854, p. 78, § 17 (1st Sess. 1854).

[10] ALASKA STAT. § 11.41.120 (1989); ARIZ.REV. STAT.ANN. § 13-1103 (1989); ARK.CODE ANN. § 5-10-104 (Michie 1987); CAL.PENAL CODE § 401 (Westlaw 1996); COLO. REV.STAT. § 18-3-104(1)(b)(Westlaw 1996); CONN.GEN.STAT. §§ 53a-54a, -56 (Westlaw 1996); DEL.CODE.ANN. tit. 11 §§ 632, 645 (1987 & Supp.1990); FLA.STAT.ANN. § 782.08 (West 1986); GA. CODE ANN. § 16-5-5 (Westlaw 1996); HAW.REV.STAT. § 707-702 (Westlaw 1996); ILL.REV.STAT. ch. 720, ¶ 5/12-31 (Westlaw 1996); IND.CODE §§ 3542-1-2, -2.5 (Westlaw 1996); KAN.STAT.ANN. § 21-3406 (1971); KY.REV.STAT. § 216.302 et seq. (Westlaw 1996);

District of Columbia do not impose explicit criminal sanctions on assisted suicide, but nonetheless condemn assisted suicide in statutes allowing withdrawal of medical treatment.[11] Three other states have definitions of criminally negligent homicide that are sufficiently broad to encompass aiding, assisting, causing or promoting suicide.[12] An additional four states impose criminal penalties under case law.[13] In total, forty-four states, the District of Columbia and two territories prohibit or condemn assisted suicide.

ME.REV.STAT.ANN. tit. 17-A, § 204 (West 1965); MICH.COMP. LAWS § 752.1027 (Westlaw 1996); MINN.STAT.ANN. § 609.215 (West 1987 & Supp.1993); MISS.CODES 97-3-49 (Westlaw 1996); MO.REV.STAT. § 565.023(1)(2) (Westlaw 1996); MONT.CODE ANN. § 45-5-105 (Westlaw 1996); NEB.REV.STAT. § 28-307 (1989); N.H.REV.STAT.ANN. § 630:4 (1986); N.J.STAT.ANN. § 2C:11-6 (West 1982); N.M.STAT.ANN. § 30-2-4 (Michie 1984); N.Y.PENAL LAW §§ 120.30, 120.35, 125.15(3), 125.25(1)(b) (McKinney 1987); N.D.CENT.CODE § 12.1-16-04 (Supp.1991); OKLA.STAT.ANN., tit. 21, §§ 813 et seq. (West 1983); OR.REV.STAT. § 163.125(1)(b) (1991); 18 PA.CONS.STAT.ANN. § 2505 (1983 & Supp.1992); P.R. LAWS ANN. tit. 33, § 4009 (1983); S.D.CODIFIED LAWS ANN. § 22-16-37 (1988); TENN.CODE ANN. § 39-13-216 (Westlaw 1996); TEX.PENAL CODE ANN. § 22.08 (West 1989); V.I.CODE ANN. tit. 14, § 2141 (1964); WASH.REV.CODE.ANN. § 9A.36.060 (West 1988); WIS.STAT.ANN. § 940.12 (West 1982).

[11] D.C. CODE ANN. § 6-2428 (Westlaw 1996); IDAHO CODE § 39152 (Westlaw 1996); NEV.REV.STAT. § 449.670 (Westlaw 1996); W.VA. CODE § 16-30-8(a) (Westlaw 1996).

[12] ALA.CODE § 13A-6-1 (Westlaw 1996); IOWA CODE § 707.5 (Westlaw 1996); WYO.STAT. § 6-2-107 (Westlaw 1996).

[13] *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (Mass. 1877); *Blackburn v. State*, 23 Ohio St. 146, 163 (Ohio 1872); *State v. Jones*, 86 S.C. 17, 67 S.E. 160, 165 (S.C. 1910); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961).

The trend toward repeal of criminal sanctions against suicide, while still regarding suicide as an indicium of mental illness, and continued prohibition of aiding or assisting suicide, has produced what appears to be a modern consensus on the subject. The modern consensus consists of an overall disapproval of suicide which is manifested through (1) not criminally punishing suicide itself,[14] but instead treating it as a medical or psychological problem;[15] (2) allowing the state to intervene to prevent someone from committing suicide; and (3) enacting criminal statues prohibiting the aiding or assisting of suicide.

VI

Plaintiffs allege that RCW 9A.36.060 violates their substantive due process rights under the Fourteenth Amendment of the United States Constitution. They argue that physician-assisted suicide fits within the broad description of the liberty aspect of the substantive due process right set forth in *Casey*:

> These matters, including the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to

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[14] Research indicates that the last prosecution in the U.S. for attempted suicide probably occurred in 1961. The North Carolina Supreme Court relied on the English common law to determine that attempted suicide was punishable as a misdemeanor. *State v. Willis*, 121 S.E.2d 854 (N.C. 1961).

[15] Washington subscribes to this view, and provides that attempts or threats to commit suicide can constitute a "likelihood of serious harm" to oneself sufficient to justify commitment. *See* RCW 71.05.020(3), RCW 71.05.240.

> define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

Casey, 112 S. Ct. at 2807.

Specifically, plaintiffs allege that mentally competent, terminally ill adults have a constitutionally protected liberty interest in committing physician-assisted suicide. The district court also addresses the issue in those terms. This narrow formulation follows the teaching of the Supreme Court in *Cruzan*, which says, "in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" *Cruzan*, 497 U.S. at 278. *See also Reno v. Flores*, 113 S. Ct. at 1447 ("'Substantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.'").

I would hold that mentally competent, terminally ill adults do not have a fundamental right to commit physician-assisted suicide. The Supreme Court has repeatedly indicated an unwillingness to expand the list of rights deemed fundamental. Physician-assisted suicide is not currently on that list. To be fundamental, a liberty interest must be central to personal autonomy or deeply rooted in history. The district court relies on language in *Casey's* plurality opinion to hold that substantive due process protects a wide range of autonomy-based liberty interests, including physician-assisted suicide. Such a reading of *Casey* is permissible, provided it is clearly understood that the liberty interests so protected are not fundamental. *Casey's* reaffirmation of the abortion right is best understood as a decision that relies heavily on *stare decisis*; the abortion right, uniquely protected under the

undue burden standard, is *sui generis*. The second test for determining the existence of fundamental rights, whether the interest is rooted in the nation's history, similarly militates against a fundamental right to physician-assisted suicide.

I would hold that mentally competent, terminally ill adults do have an autonomy-based, nonfundamental liberty interest in committing physician-assisted suicide.

A. No new fundamental rights

While the list of fundamental rights has not been definitively closed to expansion, the Court has indicated an unwillingness to find new penumbral, privacy-type fundamental rights. In *Reno v. Flores*, 113 S. Ct. 1439 (1993), the Court refuses to expand the list of fundamental rights to include a right of juveniles to be released into a noncustodial setting. *Reno* states:

> We are unaware . . . that any court—aside from the courts below—has ever held that [the asserted fundamental right exists]. The mere novelty of such a claim is reason enough to doubt that "substantive due process" sustains it; the alleged right certainly cannot be considered "'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'" *Salerno*, *supra*, 481 U.S., at 751, 107 S. Ct., at 2103 (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105, 54 S. Ct. 330, 332, 78 L. Ed. 674 (1934)).

113 S. Ct. at 1447. *See also Bowers v. Hardwick*, 478 U.S. 186, 190 (1986) ("[T]here should be . . . great resistance to expand the substantive reach of [the due process clauses of the Fifth and Fourteenth Amendments], particularly if it requires redefining the category of rights deemed fundamental.").

Bowers clearly identifies its liberty inquiries as fundamental, and states the two tests as follows:

> In *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937), it was said that this category [of rights which qualify for heightened judicial protection] includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.), where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition."

Bowers, 487 U.S. at 191-192.

These tests are distinct from the broader nonfundamental liberty inquiry of *Casey*. The sweeping description of liberty in *Casey* is never characterized as "fundamental" under the Constitution; rather, its wide purview covers all liberty protected by the Fourteenth Amendment, nonfundamental as well as fundamental.

There is no fundamental liberty interest in physician-assisted suicide. First, as discussed above in Part V, there is no history or tradition supporting any form of suicide. Second, however compelling the suicidal wishes of terminally ill patients are regarded, it cannot honestly be said that neither liberty nor justice will exist if access to physician-assisted suicide is proscribed.

B. The abortion right's strength rests on stare decisis

The *Casey* plurality states repeatedly that it is the combined force of *stare decisis* and liberty that protects a woman's right to abortion. *Casey*, 112 S. Ct. at 2804, 2808. This implies that liberty alone would be insufficient to support a new fundamental right to abortion.

The plurality never characterizes the abortion right as fundamental. This omission is significant, given the plurality's broad characterization of the liberty interest, as well as its use of the undue burden test in lieu of the strict scrutiny ordinarily applied to fundamental rights. The four-Justice dissent goes farther, stating that it would hold the abortion right to be nonfundamental:

> We are now of the view that, in terming this right fundamental, the Court in *Roe* read the earlier opinions upon which it based its decision much too broadly. Unlike marriage, procreation and contraception, abortion "involves the purposeful termination of human life." The abortion decision must therefore "be recognized as *sui generis*, different in kind from the others that the Court has protected under the rubric of personal or family privacy and autonomy."

Casey, 112 S. Ct. at 2859 (Rehnquist, C.J., concurring in the judgment in part and dissenting in part) (citations omitted). Central to the dissent's reason for wanting to call the abortion right nonfundamental is the fact that it involves the purposeful termination of human life. Abortion is *sui generis*, and the courts are on notice that these four Justices will not find fundamental any other asserted right that involves the purposeful termination of human life.

The other main end-of-life case, *Cruzan*, presumes a nonfundamental liberty interest in refusing unwanted medical treatment. This interest was subjected to ordinary balancing against the state interests, rather than strict scrutiny. *Cruzan*, 497 U.S. 261.

These cases, combined with the Supreme Court's disinclination to find new fundamental rights, compel the conclusion that a liberty interest in physician-assisted suicide, if one exists, is nonfundamental.

C. The history test does not support a liberty interest in physician-assisted suicide

In a recent English case, Lord Hoffman succinctly articulated the misperception upon which a history-based right to suicide is premised: "Suicide is no longer a crime, but its decriminalization was a recognition that the principle of self-determination should in that case prevail over the sanctity of life." *Airedale N.H.S. Trust v. Bland (C.A.)*, 2 W.L.R. 316, 351-352 (1993).

Yale Kamisar harshly criticizes this misperception:

> [T]he decriminalization of both suicide and attempted suicide did not come about because suicide was deemed a "human right" or even because it was no longer considered reprehensible. These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those who committed or attempted to commit the act were thought to be prompted by mental illness.

Yale Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" 23 **Hastings Center Report** 32 (5/93) (citing "the most comprehensive and most heavily documented law review article ever written on the subject," Thomas Marzen et al., "Suicide: A Constitutional Right?" 24 **Duq. L. Rev.** 1, 68-100 (1985)). Kamisar also quotes the comments to the Model Penal Code, which explain the elimination of criminal sanctions for suicide: "There is a certain moral extravagance in imposing criminal punishment on a person who has sought his own self-destruction . . . and who more properly requires medical or psychiatric attention." Kamisar, *id.*

As I discussed above in Part V, suicide and assisted suicide are clearly not "deeply rooted in this Nation's history and tradition." *Bowers*, 487 U.S. at 192. Nor are

suicide or assisted suicide rooted in the English Common Law as adopted by the states, or in the legal and philosophical order underlying the English Common Law.

D. The autonomy test supports a limited liberty interest in physician-assisted suicide

The district court's starting point for the autonomy inquiry is the now-famous assertion in *Casey* that"[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 112 S. Ct. at 2807. Application of this statement in the adjudication of substantive due process claims is a matter of "reasoned judgment." *Casey*, 112 S. Ct. at 2806. This throws courts into the wide-open realm of pure moral reasoning about liberty. As a practical matter, such unfettered theoretical musing could not plausibly form the basis of a constitutional fundamental rights jurisprudence. This is borne out by *Casey*'s notable omission to mention "fundamental" rights. *Casey* should therefore be read as describing more general, nonfundamental liberty.

There is scant guidance in the quoted passage from *Casey* as to what may constitute a nonfundamental liberty interest. Taken out of context, the "right to define one's own concept of existence" is so broad and melodramatic as to seem almost comical in its rhetorical flourish. But the preceding sentence in *Casey* provides a more somber and usable definition of liberty. Personal decisions which "involv[e] the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Casey*, 112 S.Ct. at 2807.

As plaintiffs and amicus Ten Surviving Family Members in Support of Physician-Assisted "Suicide" assert, a terminally ill person is dying, not eventually as all humans do, but imminently. Often, the decline to death is not only painful, but debilitating and demoralizing. Ideally, terminally ill people will be surrounded by caring, supportive family members, doctors, and friends, who will be able to alleviate the pain and the low morale. But ultimately, many of those who are terminally ill will face a choice of whether to continue the slow decline to death, or instead to truncate their lives.

The Hemlock Society's how-to suicide book, *Final Exit* illustrates that there are many feasible methods of ending one's life. But many of the choices are not terribly dignified. *Casey* says that liberty protects not only choices that are personal, intimate and central to autonomy, but also that are central to personal dignity. Suicide by physician-prescribed medication is seen by some as an inherently more dignified way to hasten an imminent and inevitable death than other methods in common usage.

To the extent that *Casey* defines the outer limits of the Constitution's nonfundamental liberty right, it can plausibly be said to include decisions about the manner and timing of one's death.

VII

Whatever test is ultimately used to evaluate the constitutionality of RCW 9A.36.060, the plaintiffs' liberty interest must be compared against the state interests underlying the statute.

The State asserts three interests: (1) preventing suicide, (2) protecting vulnerable individuals from abuse or undue influence and (3) preserving and protecting the lives of its people. It asserts that the interest in preventing suicide applies equally to all the state's citizens; the State does

not evaluate the quality of life among its citizenry, and preserve and protect only those whose lives are deemed "worth living."

Washington courts recognize four state interests common to end-of-life cases: (1) the preservation of life, (2) the protection of the interests of innocent third parties, (3) the prevention of suicide, and (4) the maintenance of the ethical integrity of the medical profession. *In re Guardianship of Grant*, 747 P.2d 445, 451 (Wash. 1987); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983). The Supreme Court has also recognized all four of these state interests. *Cruzan*, 497 U.S. at 271.

The four governmental interests recognized by Washington courts and endorsed by the Supreme Court are all very strong, and apply with undiminished vigor to justify RCW 9A.36.060's prohibition of physician-assisted suicide for mentally competent, terminally ill adults. Any one of these interests would be sufficient to support this application of the statute under a rational relationship test. Were it necessary for me to do so, I would even be inclined to hold that the cumulative force of all four governmental interests is sufficient to enable this application of the statute to withstand strict scrutiny.

A. The preservation of life

This interest has been addressed extensively in the cases involving withdrawal of nutrition and hydration. In particular, *Grant* and *Colyer* describe the contours of Washington's interest in the preservation of life. The *Colyer* court held that the interest "weakens . . . in situations where continued treatment serves only to prolong a life inflicted with an incurable condition." *Colyer*, 660 P.2d at 743. The *Grant* court held the interest "weaken[s] considerably . . . if treatment will merely postpone death

for a person with a terminal and incurable condition." *Grant*, 747 P.2d at 451.

It may be tempting to extrapolate from these cases a principle that terminally ill patients seeking to commit physician-assisted suicide fall within the zone where the state's interest in preserving life is weakened. Such an extrapolation would be improper. The state's interest is weakened only where continued medical treatment would do nothing more than postpone death. This is the holding of both *Colyer* and *Grant*, and it matches the line drawn in Part I of this opinion, between discontinuing medical treatment on one hand, and physician-assisted suicide and euthanasia on the other hand. As applied to terminally ill adults seeking physician-assisted suicide, the state's interest in preserving life remains at full strength.

The state's interest in preserving life is equally strong when applied to terminally ill patients seeking to commit assisted suicide as it is when applied to the general populace. The analogy to abortion is a rough one: in the abortion context, the Supreme Court tells us that the state's interests in fetal life are weaker before viability than they are once the fetus becomes viable. *See Casey*, 112 S. Ct. at 2804. A state's interest in preserving human life is stronger when applied to viable beings than it is when applied to nonviable beings. Like a first-trimester fetus, a person kept alive by life-sustaining treatment is essentially nonviable. A terminally ill patient seeking to commit physician-assisted suicide, by contrast, is essentially viable. The patient may be inexorably approaching the line of nonviability. But the patient is still on the viable side of that line, and consequently enjoys the full protection of the state's interest in preserving life.

B. The protection of the interests of innocent third parties

The question of physician-assisted suicide raises many issues involving the interests of innocent third parties. Constitutional protection for a right to assisted suicide might spawn pressure on the elderly and infirm—but still happily alive—to "die and get out of the way."[16] Also at risk are the poor and minorities, who have been shown to suffer more pain (i.e. they receive less treatment for their pain) than other groups. *See* Yale Kamisar, "Against Assisted Suicide—Even a Very Limited Form," 72 **U. Det. Mercy L. Rev.** 735, 737-739 (1995). Further, like the elderly and infirm, they, as well as the handicapped, are at risk of being unwanted and subjected to pressure to choose physician-assisted suicide rather than continued treatment. Kamisar quotes the New York State Task Force on Life and the Law:

> [I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society—only that they are not exempt from the prejudices manifest in other areas of our collective life.

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[16] A recent computer search revealed 83 news stories with this phrase, including the famous 1984 statement by Colorado Governor Lamm.

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> [Many patients] in large, overburdened facilities serving the urban and rural poor . . . will not have the benefit of skilled pain management and comfort care. Indeed, a recent study found that patients treated for cancer at centers that care predominantly for minority individuals were three times more likely to receive inadequate therapy to relieve pain. Many patients will also lack access to psychiatric services. Furthermore, for most patients who are terminally or severely ill, routine psychiatric consultation would be inadequate to diagnose reliably whether the patient is suffering from depression.

Kamisar, *Id.* at 738 (quoting The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* at 125, 143 (1994)). Pain and suffering are directly related to the prevalence of requests for assisted suicide. Kamisar reports that

> Although pain is notoriously undertreated in this country, "according to experts in the field of pain control, almost all terminally ill patients can experience adequate relief with currently available treatments." Thus, . . . suicidal ideation and suicide requests "commonly . . . dissolve with adequate control of pain and other symptoms."

Id. (quoting Judith Ahronheim & Doron Weber, *Final Passages: Positive Choices For the Dying and Their Loved Ones* 102 (1992); Kathleen Foley, "The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide," **J. Pain & Symptom Management** 289, 290 (1991)). Kamisar repeatedly suggests the explanation for inadequate control of pain: lack of universal access to adequate medical care. *Id.* at 738, 744 n.43.

People request physician-assisted suicide because they are in pain or are otherwise suffering. If their suffering is alleviated, they will likely withdraw their requests for physician-assisted suicide. We the courts are asked, in a nation of inadequate and unequal access to medical care for the alleviation of pain and suffering, to create a constitutional right to physician-assisted suicide. Surely this is a case of misplaced priorities.

Plaintiffs suggest that adequate procedural safeguards can be implemented to protect the interests of innocent third parties. This assertion is refuted by the experience of The Netherlands, where physician-assisted suicide and euthanasia are nominally legal.[17] At the outset, The Netherlands had guidelines: the patient must be incurably ill, the patient's suffering must be subjectively unbearable, the request for termination should be in writing, and there should be adequate consultation with other physicians before euthanasia was carried out. Lagerway at 439.

In 1991, the Dutch Government released a report on the practice of euthanasia and physician-assisted suicide in The Netherlands. Commissie Onderzoek Medische Praktijk Inzake Euthanasie, *Medische Beslissingen Rond Het Levenseinde* (1991) (the "Remmelink Report"). According to the Remmelink Report, 2.1% of all deaths in The Netherlands are due to physician-assisted suicide or euthanasia. Another 7% are due to the alleviation of pain

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[17] Physician-assisted suicide and euthanasia are prohibited by the Penal Code of the Netherlands, art. 293-294. *See* John Keown, "Euthanasia in The Netherlands: Sliding Down the Slippery Slope? " 9 **Notre Dame J. Law, Ethics & Pub. Pol.** 407, 409-410 (1995). The courts have allowed physicians who participate in euthanasia to go unpunished since 1973. Nederlandse Jurisprudentie (1973), no. 183, District Court of Leeuwarden, February 21, 1973; trans., Walter Lagerway, 3 **Issues in Law and Med.** 429, 439-442 (1988).

or symptoms where the physician had the explicit (total or partial) purpose of shortening life. In 1990: 2300 people were euthanized upon request, 400 died as a result of physician-assisted suicide, 1000 died from involuntary euthanasia (patients were killed without their knowledge or consent), and 8100 died as a result of doctors deliberately giving them overdoses of pain medication (again, 61% of this category were killed without their knowledge or consent).[18]

Critics of this data would respond that the Dutch experiment has focused mainly on euthanasia, rather than physician-assisted suicide. But even proponents of assisted suicide have begun to abandon the distinction between physician-assisted suicide and euthanasia:

> To confine legalized physician-assisted death to assisted suicide unfairly discriminates against patients with unbelievable suffering who resolve to end their lives but are physically unable to do so. The method chosen is less important than the careful assessment that precedes assisted death.

Franklin G. Miller et al., "Sounding Board: Regulating Physician-Assisted Death," 331 **New England J. Med.** 119, 120 (1994). Likewise, the AMA Code of Ethics § 2.211 uses identical language to condemn both euthanasia and physician-assisted suicide.

The poor, the elderly, the disabled and minorities are all at risk from undue pressure to commit physician-assisted suicide, either through direct pressure or through inadequate treatment of their pain and suffering. They cannot be adequately protected by procedural safeguards, if the Dutch experience is any indication. The only way to

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[18] Keown, *supra* note 17, at 419.

achieve adequate protection for these groups is to maintain a bright-line rule against physician-assisted suicide.

But it is not only people at the margins who are imperilled by the threat of a constitutional right to physician-assisted suicide. Such a right could disrupt the established legal order of wills, trusts, life insurance, annuities, pensions, and other estate planning tools employed by many Americans. Many life insurance policies have suicide clauses in them, which negate the insurer's liability if the insured commits suicide. Many states have statutes like Washington's Slayer's Act, which preclude participants in the unlawful killing of another person from acquiring property or receiving benefits as the result of the death.[19] A sampling of cases demonstrates that these and related concerns are real. In *People v. Matlock*, 336 P.2d 505 (Cal. (In Bank) 1959) and *Godsparek v. State*, 1993 WL 213854 (Ala. Cr. App. 1993), the defendants were tried for killing people who had hired or requested to be killed because they wanted to die, but did not want to void their life insurance by committing suicide. In *Keddie v. Delaware Violent Crimes Compensation Board*, 1991 WL 215655 (Del Super. 1991), Ms. Keddie was denied compensation under the Compensation for Innocent Victims of Crime Act for her husband's suicide. He committed suicide at the encouragement of Anthony Sabbato, who was convicted of promoting a suicide. The court reasoned that Ms. Keddie's husband was not an innocent victim of crime, insofar as he contributed to his own death. In *Holmes v. Morgan*, 899

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[19] *See* RCW 11.84.010 *et seq*. The applicability of this statute to cases of assisted suicide has not yet been decided in Washington courts. However, RCW 11.84.900 provides: "This chapter . . . shall be construed broadly to effect the policy of this state that no person shall be allowed to profit by his own wrong, wherever committed."

P.2d 738 (Or. App. 1995), a distraught young man changed the named beneficiary on his life insurance policy from his parents to a friend, who may have assisted him in a suicide attempt. He later committed suicide without assistance. The Oregon Court of Appeals held that the friend could receive the policy proceeds. Finally, in *Wilmington Trust Co. v. Clark*, 424 A.2d 744 (Md. 1981), the Maryland Supreme Court considered whether a woman could bring a contract or tort action against her former husband's estate, on the ground that his suicide deprived her of alimony.

The interests of many innocent third parties are implicated by a putative right to physician-assisted suicide. Most obviously, the poor, minorities and the disabled are at risk of suffering undue indifference or pressure to commit physician-assisted suicide. Less obviously, a right to physician-assisted suicide could severely disrupt the economic interests of the relatives, partners and associates of those who commit physician-assisted suicide.

C. The prevention of suicide

The state interest in preventing suicide runs directly contrary to any claimed right to physician-assisted suicide. It is a longstanding interest. In Washington, committing or attempting suicide was punishable as a crime at least from 1909 to 1976. The 1976 repeal arguably represents a recognition that suicide is not a criminal problem, but rather one of mental and public health.[20] Suicide is a leading cause of death in Washington for all age groups, 15-54. Washington State Dep't of Health, *Washington State Annual Summary of Vital Statistics 1989* 38-39 (1990). Suicide is the cause of 1.8% of all deaths in

[20] A review of the legislative history and the state archives reveals that the repeal was enacted without comment from the legislature.

Washington. *Id.* at 37. Aiding suicide has been codified as a crime in Washington law since 1854, and continues to the present, in RCW 9A.36.060.

Plaintiffs imply that the prevention of suicide is merely a derivative of the state's general interest in protecting life. Even if this were the entire substance of the state interest in preventing suicide, the state's interest in preserving life remains at full strength in the case of terminally ill patients seeking to commit physician-assisted suicide.

However, the history of state regulation of suicide and the modern consensus on the regulation of suicide indicates that the state's interest in preventing suicide goes deeper than just keeping people alive. The state recognizes suicide as a manifestation of medical and psychological anguish; people with suicidal tendencies are suffering. The state's interest is in addressing and, where possible, relieving that suffering.

Plaintiffs make a compelling argument that in some cases of terminally ill patients, the suffering is due not to physical pain or to psychological illness, but to the knowledge that their terminal illness will slowly dissolve their physical and mental faculties, stripping them of dignity in their last days. But also compelling are the data indicating that a high percentage of persons withdraw their suicide requests once they receive adequate treatment for depression, pain, and the like. *See, e.g.*, Kamisar, 72 **U. Det. Mercy L. Rev.** at 744.

The state's interest in preventing suicide is distinct from its interest in preserving life, and it does not diminish with the onset and advancement of terminal illness.

D. The maintenance of the ethical integrity of the medical profession

It is sanctionable unprofessional medical conduct in Washington to "possess[ ], use, prescri[be] for use, or distribut[e] . . . controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes . . . " RCW 18.130.180(6). Furthermore, "[t]he use of a nontraditional treatment by itself shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed." RCW 18.130.180(4). These statutory provisions demonstrate that, in addition to the prohibitions of RCW 9A.36.060, physicians are subject to professional sanctions for prescribing drugs to their patients in order to assist those patients to commit suicide.

While not legally binding, the AMA Code of Ethics provides clear guidance on the current position of medical ethicists. Section 2.211 of the American Medical Association's Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs ("AMA Code of Ethics") prohibits physician participation in physician assisted suicide. In virtually identical language to its condemnation of euthanasia, section 2.211 provides:

> Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g. the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
>
> It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may

> come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Because it is contrary to Washington statutory law, reinforced by the AMA Code of Ethics, it would violate the state's interest in maintaining the ethical integrity of the medical profession to allow physicians to participate in physician assisted suicide.

VIII

In reviewing a statute's constitutionality under the substantive due process clause, courts should apply one of two tests. If the right asserted is fundamental, the statute is subjected to strict scrutiny, under which it must be narrowly tailored to serve a compelling state interest. If the liberty interest is not fundamental, the statute is subjected only to the "unexacting" inquiry of whether the statute rationally advances some legitimate governmental purpose. *Reno v. Flores*, 113 S. Ct. at 1447-1449.

Because I would hold that the liberty interest of mentally competent, terminally ill adults in committing physician-assisted suicide is not a fundamental right, I would use the latter test, which has sometimes been called the rational relationship test.

The nonfundamental liberty interest at stake here is the right of mentally competent, terminally ill adults to commit physician-assisted suicide. This interest is rooted in the liberty to make intensely private choices that are central to personal dignity and autonomy. The exercise of this non-fundamental liberty interest is barred in Washington by RCW 9A.36.060, which states that promoting a suicide attempt is a criminal offense. The Washington statute rationally advances four legitimate state interests: the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession. Under the rational relationship test, RCW 9A.36.060 is valid.[21]

IX

The district court also holds that the Washington statute violates the Equal Protection Clause. Its analysis is based upon two premises, both of which are incorrect, and fall together. First, it assumes that *Cruzan*-type patients are similarly situated to the patients in this case. Second, it holds that the differentiation between these types of patients is subject to, and does not withstand, strict scrutiny. *Compassion in Dying*, 850 F. Supp. at 1466.

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[21] The Supreme Court has occasionally appeared to employ a straight balancing test instead of the strict scrutiny-versus-rational relationship dichotomy. *E.g., Cruzan*, 497 U.S. at 278-279 ("whether [the individual's] constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests"). Even under such a balancing test, I would hold that the state's four interests—in preserving life, protecting the interests of innocent third parties, preventing suicide, and maintaining the ethical integrity of the medical profession—outweigh the plaintiffs' autonomy-based liberty interest in committing physician-assisted suicide.

Cruzan-type patients are being subjected to unwanted life-saving medical treatment, from which they have a constitutionally protected right to be free. The patients in this case, though also terminally ill, are not seeking any such freedom from treatment. Rather, they are seeking medical assistance in ending their lives. The district court rejected arguments that the distinction between the two groups is one between "natural" and "artificial" deaths. There are dozens of ways that the two groups of patients could be distinguished or associated, not the least of which is the dramatic difference in the nature of their constitutional rights. One group has not just an interest but a right to be free from unwanted medical treatment. The other group has an interest, but not a protected right, in committing physician-assisted suicide. Washington statutes clearly distinguish the two groups, as does the AMA Code of Ethics. They are not similarly situated, and are therefore not subject to an equal protection analysis.

Even though the physician plaintiffs argue that the two groups are similarly situated, the patients in this case are neither a suspect classification nor holders of fundamental rights. The patients' position is entitled to no more than rational basis review. Strict scrutiny is only used where people are categorized into suspect classifications (e.g., race) or suffer the infringement of a constitutionally protected fundamental right. "[T]he pertinent inquiry is whether the [classification] advances legitimate legislative goals in a rational fashion. The Court has said that, although this rational basis standard is 'not a toothless one,' it does not allow us to substitute our notions of good public policy." *Schweiker v. Wilson*, 450 U.S. 221 (1981). *See also New York Transit Auth. v. Beazer*, 440 U.S. 568 (1979); *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450 (1988). The state's interests in protecting life, preventing suicide, protecting the interests of third parties,

and preserving the ethical integrity of the medical profession are strong, perhaps even compelling. Even if the two groups—patients refusing unwanted medical treatment and mentally competent terminally ill adults seeking to commit physician-assisted suicide—were similarly situated, the distinction between them rests solidly on a rational basis and is constitutionally valid under the Equal Protection Clause.

X

The issue of whether mentally competent, terminally ill adults have a constitutionally protected right to commit physician-assisted suicide is one of the most difficult, divisive and heart-wrenching issues facing the courts today. The correlative issue of whether terminally ill loved ones ought to be allowed to commit assisted suicide is likewise one of the most difficult, divisive and heart-wrenching issues facing American society. The former is a constitutional issue for the courts; the latter is a moral question for society as a whole.

The two issues are not the same. The latter requires us —all of us, not just judges—to engage in a soul-searching dialogue about our collective morals. Given the tremendous advances in twentieth-century medical technology and public health, it is now possible to live much longer than at any time in recorded history. We have controlled most of the swift and merciful diseases that caused most deaths in the past. In their place are a host of diseases that cause a slow deterioration of the human condition: cancer, Alzheimer's disease, and AIDS are but a few. This change has forced us to step back and reexamine the historic presumption that all human lives are equally and intrinsically valuable. Viewed most charitably, this reexamination may be interpreted as our struggle with the question whether we as a society are willing to excuse the terminally

ill for deciding that their lives are no longer worth living. Viewed less charitably, the reexamination may be interpreted as a mere rationalization for housecleaning, cost-cutting and burden-shifting—a way to get rid of those whose lives we deem worthless. Whether the charitable or uncharitable characterization ultimately prevails is a question that must be resolved by the people through deliberative decisionmaking in the voting booth, as in Washington in 1991, California in 1992 and Oregon in 1994, or in the legislatures, as recently undertaken in Michigan and New York. This issue we, the courts, need not—and should not—decide.

Instead, we should restrict our decision to the former issue: whether mentally competent, terminally ill adults have a constitutionally protected liberty interest in committing physician-assisted suicide. This is the first federal appellate case in our nation's history to address the issue of physician-assisted suicide. To declare a constitutional right to physician-assisted suicide would be to impose upon the nation a repeal of local laws. Such a declaration would also usurp states' rights to regulate and further the practice of medicine, insofar as a right to physician-assisted suicide flies in the face of well-established state laws governing the medical profession. Finally, the rationales under which we are asked to create this right fail adequately to distinguish physician-assisted suicide as a unique category. If physician-assisted suicide for mentally competent, terminally ill adults is made a constitutional right, voluntary euthanasia for weaker patients, unable to self-terminate, will soon follow. After voluntary euthanasia, it is but a short step to a "substituted judgment" or "best interests" analysis for terminally ill patients who have not yet expressed their constitutionally sanctioned desire to be dispatched from this world. This is the sure

and inevitable path, as the Dutch experience has amply demonstrated. It is not a path I would start down.

I would hold that the four state interests discussed above are sufficiently strong to sustain the constitutionality of RCW 9A.36.060 as applied to plaintiffs' asserted liberty interest.

I dissent.

FERNANDEZ, Circuit Judge, dissenting:

I join in Judge Beezer's dissenting opinion with one caveat. Nothing in his opinion, or in that of the majority, convinces me that there is any constitutional right whatever to commit suicide. In my view, no one has an even nonfundamental *constitutional right* to become what our legal ancestors pithily denominated a *felo de se*. *See e.g.*, Sir Edward Coke, *Institutes of the Laws of England*, 3d Institute, 54 (Brooke ed. 1797) (1644); 1 Sir Matthew Hale, *Pleas of the Crown* 411 (Nutt ed. 1736) (1680); 4 Sir William Blackstone, *Commentaries on the Laws of England* 189 (15th ed. 1809) (1765). The arguments for and against suicide raise an issue which would elicit competing responses from even our most well trained moral philosophers. Like so many other issues, it is one "for the people to decide." *Guadalupe Org., Inc. v. Tempe Elementary Sch. Dist. No. 3*, 587 F.2d 1022, 1027 (9th Cir. 1978). Our Constitution leaves it to them; it is they and their representatives who must grapple with the riddle and solve it.

KLEINFELD, Circuit Judge, dissenting:

I join in Judge Beezer's dissenting opinion, with two qualifications.

First, I doubt that there is a constitutional right to commit suicide. "[N]o 'substantive due process' claim can be maintained unless the claimant demonstrates that the state has deprived him of a right historically and traditionally protected against state interference." *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841, 2860 (1990) (Scalia, J. concurring). Suicide has not been traditionally or historically protected as a right:

> American law has always accorded the State the power to prevent, by force if necessary, suicide--including suicide by refusing to take appropriate measures necessary to preserve one's life; the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate" are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; . . . It is quite impossible (because the Constitution says nothing about the matter) that [Missouri's] citizens will decide upon a line less lawful than the one we would choose; and it is unlikely (because we know no more about "life-and-death" than they do) that they will decide upon a line less reasonable.

Cruzan, 110 S. Ct. at 2859 (Scalia. J. concurring).

That a question is important does not imply that it is constitutional. The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions

would be decided by the judiciary. The majority treats the remark in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992), about "the most intimate and personal choices a person may make . . . the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," *id.* at 2807, as a basis for constitutionalizing any really important personal decision. That an issue is important does not mean that the people, through their democratically elected representatives, do not have the power to decide it. One might suppose that the general rule in a democratic republic would be the opposite, with a few exceptions. Judge Beezer's view, that the statement is made in the *sui generis* context of abortion law, is sounder than the majority's. There is a difficulty with expanding the quoted language from *Casey* beyond abortion, in the face of *Bowers v. Hardwick*, 106 S. Ct. 2841, 2944-45 (1986), and we lack authority to overrule that decision of a higher court.

We do not need, however, to decide whether suicide is a constitutionally protected right. As Judge Beezer explains, even if it is, the State of Washington has a rational basis for preventing assisted suicide. It is not necessary to agree with Judge Beezer, that there is a nonfundamental constitutionally protected right to commit suicide, or with Judge Fernandez, that there is not. Either way, the district court erred, for the reasons stated by Judge Beezer.

Second, the majority says there is "little, if any, difference for constitutional or ethical purposes" between providing pain killing medication for the purpose of relieving pain, knowing that it will at some dosage cause death, and providing medication for the sole purpose of causing death. I would go further than Judge Beezer's characterization of this as a "gray area." I think the majority's proposition is exactly wrong. When General

Eisenhower ordered American soldiers onto the beaches of Normandy, he knew that he was sending many American soldiers to certain death, despite his best efforts to minimize casualties. His purpose, though, was to liberate the beaches, liberate France, and liberate Europe from the Nazis. The majority's theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers. Knowledge of an undesired consequence does not imply that the actor intends that consequence. A physician who administers pain medication with the purpose of relieving pain, doing his best to avert death, is no murderer, despite his knowledge that as the necessary dosage rises, it will produce the undesired consequence of death.

Justice Holmes was the leading advocate of his time for the general proposition that "[a]cts should be judged by their tendency under the known circumstances, not by the actual intent which accompanies them." Holmes, *The Common Law* 54 (Harvard Univ. Press 1967)(1881). When applying this general principle to a specific case, however, Holmes qualified it, conceding that "when words are used exactly, a deed is not done with intent to produce a consequence unless that consequence is the aim of the deed." *Abrams v. United States*, 250 U.S. 616, 627 (1919) (Holmes J. dissenting). There is no novelty to the distinction between intended purpose and foreseen but undesired consequence. "It is deliberate purpose that constitutes wickedness and criminal guilt, and such names as 'outrage' and 'theft' imply deliberate purpose as well as the mere action." Aristotle, *Rhetoric*, book I, chap. 13, at 79 (Roberts trans. 1954). Jurors can no longer be instructed that "the law presumes that a person intends the ordinary consequences of his voluntary acts," in a case requiring purposeful conduct, because the instruction presumes away the prosecution's burden of proving

criminal intent. *Sandstrom v. Montana*, 442 U.S. 510, 513 (1979).

It is very difficult to judge what ought to be allowed in the care of terminally ill patients. The Constitution does not speak to the issue. People of varying views, including people with terrible illnesses and their relatives, physicians, and clergy, can, through democratic institutions, obtain enlightened compromises of the complex and conflicting considerations. They can do so at least as well as we judges can, and nothing in the Constitution prevents them from making the law.

APPENDIX B

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

COMPASSION IN DYING, a Washington nonprofit corporation; Jane Roe; John Doe; James Poe, Harold Glucksberg, M.D., Plaintiffs--Appellees, v. STATE OF WASHINGTON; Christine Gregoire, Attorney General of Washington, Defendants-Appellants.	No. 94-35534 D.C. No. CV-94-119BJR O R D E R

Before: HUG, Chief Judge, BROWNING, SCHROEDER, FLETCHER, PREGERSON, REINHARDT, BEEZER, WIGGINS, THOMPSON, FERNANDEZ, and KLEINFELD, Circuit Judges.

The majority opinion is amended as follows:

1.) slip op. at 3118, line 20. Insert the word "attempt" after "suicide" and before "when".

2.) slip op. at 3127, note 9. Lines 5-6 of the second paragraph of the note on p. 3127. Delete "Casey, 112 S.Ct. at 2829-30." and replace it with the following: "Planned Parenthood v. Casey, 112 S.Ct. 2791, 2829-30 (1992)."

3.) slip op. at 3179, note 87. Delete rest of sentence after "cited in" and replace with the following: "Richard Posner, Age and Old Age 239 & n. 11 (1995).

4.) slip op. at 3186, n. 98, line 3. Delete "Richard Posner, Age and Old Age 224 (1995)" and replace it with the following: Posner, infra note 87, at 224.

5.) slip op. at 3205, n.124, line 1. Delete "74" after "note" and replace it with "87".

6.) slip op. at 3214, next to last line of text. Change "it" to "its reasoning".

7.) slip op. at 3214, n. 138, first line. Change "ruling" to "analysis".

8.) slip op. at 3214, n. 138, second to last line. Insert "the rationale on which" after "Because"; delete "erroneously" before "decided"; delete comma after "decided: and add "was clearly erroneous,".

APPENDIX C

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

COMPASSION IN DYING, a Washington nonprofit corporation; JANE ROE; JOHN DOE; JAMES POE, HAROLD GLUCKSBERG, M.D., *Plaintiffs-Appellees*, v. STATE OF WASHINGTON; CHRISTINE GREGOIRE, Attorney General of Washington, *Defendants-Appellants*.	No. 94-35534 D.C. No. CV-94-119-BJR AMENDED ORDER

Filed June 12, 1996

Before: Procter Hug, Jr., Chief Judge, James R. Browning, Mary M. Schroeder, Betty B. Fletcher, Harry Pregerson, Stephen Reinhardt, Robert R. Beezer, Charles Wiggins, David R. Thompson, Ferdinand F. Fernandez, and Andrew J. Kleinfeld, Circuit Judges.

Dissent by Judge O'Scannlain; Dissent by Judge Trott.

ORDER

* * *

An active judge sua sponte requested that the full court rehear this case en banc. The request failed to

receive a majority of the votes of the non-recused active judges. The request is rejected.

O'SCANNLAIN, Circuit Judge, joined by TROTT and KLEINFELD, Circuit Judges, dissenting from order rejecting request for rehearing en banc by the full court:

By promulgating a new constitutional right, one unheard of in over two hundred years of American history, six men and two women--endowed with life tenure and cloaked in the robes of this court--have enacted by judicial fiat what the people of the State of Washington declined to do at the polls only five years ago.[1] By our failure to convene the full court to rehear this case, a mere one-third of the twenty-four active judges[2] eligible to vote has been empowered to strike down criminal laws, not just in Washington, but in Alaska, Arizona, California, Hawaii, and Montana, as well as in Idaho and Nevada to the extent they criminalize assisted suicide through common law, as they currently do. Because our failure to rehear this case as a full court permits a minority of our court to nullify the public will without adequate justification, I must respectfully dissent.

I

The Ninth Circuit Court of Appeals is the only appellate court in the federal system (indeed, in either the federal or state appellate systems) which permits a case to

[1] In November 1991, the people of Washington rejected Initiative 119, which would have permitted physicians to assist terminally ill patients in committing suicide.

[2] At the time of the filing of this order there are five vacancies on this 28-judge court. *See* 28 U.S.C. § 44. However, one judge took senior status after the voting began, but prior to this filing, reducing the current membership to 23.

be reheard by a limited en banc court.[3] In every other federal court of appeals ranging from the smallest, six judges on the First Circuit,[4] to the second largest, seventeen judges on the Fifth Circuit,[5] the full court sits en banc whenever a majority of that court has determined that a three-judge panel decision merits rehearing.

When Congress enlarged the Ninth Circuit from thirteen to twenty-three judges in 1978, it also authorized any court of appeals with more than fifteen active judges to "perform its en banc function by such numbers of members of its en banc court as may be prescribed by rule of the court...." Omnibus Judgeship Act of Oct. 20, 1978, Pub. L. No. 95-486, § 6, 92 Stat. 1629, 1633 (codified at 28 U.S.C. §§ 41 note, 46(c)). Pursuant to this congressional authorization, the Ninth Circuit adopted the eleven-judge limited en banc option in 1980. *See* Ninth Circuit R. 35-3. Neither of the other eligible circuits has done so.

This is only the third time, according to published orders, that our court has had a vote on whether to rehear a case by the full court. None of the three efforts has been successful. In 1980, the court failed to rehear a nine-judge decision[6] after the court was increased by ten judges to twenty-three. *See United States v. Penn*, 647 F.2d 876,

[3] *See* Arthur D. Hellman, *Maintaining Consistency in the Law of the Large Circuit*, *in* Restructuring Justice 62-70 (Arthur D. Hellman ed., 1990).

[4] Maine, Massachusetts, New Hampshire, Puerto Rico, and Rhode Island. 28 U.S.C. §§ 41, 44.

[5] Louisiana, Mississippi, and Texas. 28 U.S.C. §§ 41, 44.

[6] At the time of the *Penn* decision, there were 10 active members of this court and three vacancies. One of the active judges did not participate in the case.

889-91 (9th Cir.) (individual dissents from failure to grant rehearing en banc by full court by Judges Fletcher, Pregerson, and Ferguson), *cert. denied*, 449 U.S. 903 (1980). In 1994, a judge called for rehearing by the full court in *Campbell v. Wood*, where an eleven-judge limited en banc court held by a six-to-five vote that hanging, as a form of execution of the death penalty, did not violate the Eighth Amendment prohibition against cruel and unusual punishment. *See Campbell v. Wood*, 20 F.3d 1050, 1051, 1053 (Part II) (9th Cir.) (Reinhardt, J., dissenting from failure to grant rehearing en banc by full court), *cert. denied*, 114 S. Ct. 2125 (1994).

Judge Reinhardt urged in his dissent from full court rehearing in *Campbell* that the issue in that case was of the utmost constitutional importance and that it was wrongly decided. 20 F.3d at 1053. The same principles apply to this case, but with even greater force. In contrast to *Campbell* which simply followed existing law, affirmed the validity of the Washington statute, and made no new constitutional pronouncements, *Compassion* discovers and enunciates a new constitutional right, not found in the text of the Constitution or even hinted at in any Supreme Court opinion since 1791. In my view, such a solemn and sweeping declaration, particularly when it strikes down the existing statutes and common law of eight out of the nine states of this circuit, should not be undertaken without the express approval of a majority of the members of this court. The public's confidence in the legitimacy of judicial nullification of the will of the electorate is at stake, especially when only one-third of the eligible members of the court has signed on to the holding in this case.

Yet, while disappointing, it is not surprising that we will not rehear this case as a full court. Although one can only speculate, the motives for declining rehearing by the full court undoubtedly run a full spectrum. Some of my

colleagues may, of course, be persuaded that the legal analysis made by the eight-judge majority opinion is indeed sound and should not be revisited. There may be those who oppose full court en banc rehearing to avoid further delay in the hope that the Supreme Court will promptly grant certiorari, which the Attorney General of Washington intends to seek, to reverse an embarrassing judicial excess without further ado. Although our Pasadena Courthouse has a courtroom designed for full court en banc rehearings, there may be those who genuinely tremble at the prospect of up to twenty-eight judges looming from three tiers of benches, intimidating the hapless appellate advocates. Some of my colleagues may believe that full court en banc rehearing should never occur in any case; there may be those who believe that the court elected in 1980 to use the limited (eleven-judge) en banc *in lieu of* a full court en banc.[7] And there may be those who, knowing that we have never voted to rehear a case before the entire court since the procedure was established in 1980, fear the disruptive effect which such an event could have on the current congressional efforts to split the circuit or, as presently cast, to establish a commission to examine the realignment of the appellate courts in this country.

Notwithstanding all the foregoing reasons which might possibly have contributed to the decision not to rehear this case as a full court, I respectfully submit that they are outweighed by our obligation to sustain the

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[7] Interestingly enough, the language of the limited en banc option statute is capable of such interpretation. *See* 28 U.S.C. §§ 41 note, 46(c). On balance, however, the context of our rule and the orders which implement it support the conclusion that our court never intended to renounce full court en banc in favor of a single limited en banc rehearing. *See* Ninth Cir. General Order 5; Ninth Cir. R. 35-3.

integrity of this court in the face of a shockingly broad act of judicial legislation.

II

Contrast this case with the Oregon experience. Unlike the voters of the State of Washington, the electorate in Oregon passed a ballot measure which specifically provided for a regime of physician-assisted suicide and set forth specific procedural safeguards.[8] When such a statute is reviewed by this court, it enjoys the benefit of presumptive constitutionality because it has been duly enacted into law through the legislative process. Indeed, the constitutionality of the Oregon statute will soon be tested in this court in the appeal of *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (calendared for appeal before Ninth Circuit, July 9, 1996).

Unlike the *Compassion* majority, I will not comment on the merits of another case pending before our court. *Compassion in Dying v. Washington*, 79 F.3d 790, 837-38 (9th Cir. 1996) (en banc) (declaring that the district court "clearly erred" in *Lee*); *see Lee v. Oregon*, No. 94-6467, at 8 n.7 (D. Or. May 9, 1996) (unpublished order denying motion to lift or stay injunction) ("the state defendants agree with plaintiffs that the Ninth Circuit's comments about *Lee* in *Compassion in Dying* decision were dicta 'and could be considered gratuitous and inappropriate'"). What is significant, however, in the context of *Compassion*, is that the federal judge in Oregon "did *not* hold that states, including Oregon, are precluded from passing laws legalizing physician assisted suicide for terminally ill patients." *Lee*, No. 94-6467, at 24 (emphasis added). The point is that Oregonians did not need the "good offices" of

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[8] Measure 16 (codified as Or. Rev. Stat. §§ 127.800-127.995).

the Ninth Circuit to make their legislative decision. Because of the *Compassion* majority, however, eight other states have had such legislation imposed upon them by court edict and, thus, have been deprived of their own right to choose.

By exempting an ill-defined class from Washington's statutory prohibition against assisted suicide, the majority simply appropriates the legislative power of the State of Washington. As Judge Kleinfeld eloquently writes: "That a question is important does not mean that it is constitutional. The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." *Compassion*, 79 F.3d at 857, 858 (Kleinfeld, J., dissenting).

Indeed, the plaintiff-physicians in *Compassion* present a strong legislative argument, but one that is best addressed to the popularly elected representatives of Washington, who are more capable than we of deciding whether to recognize the exception desired by the plaintiffs here. *See Compassion*, 79 F.3d at 839, 857 (Beezer, J., dissenting) ("To declare a constitutional right to physician-assisted suicide would be to impose upon the nation a repeal of local laws. . . . [and to] usurp states' rights to regulate and further the practice of medicine . . . .").

The difference between the Oregon and Washington experiences is compelling. In Oregon, the people acted out of their own free will to legislate; in Washington, the will of this court is imposed on the people contrary to their manifest intent.

III

As to the merits of this case, the eight-judge opinion in *Compassion* simply goes too far for an inferior federal court restricted to following Supreme Court precedent.

With utmost respect to my eight colleagues, I am convinced that by misapplying language uniquely crafted by the Supreme Court for application in circumstances wholly inapposite to those presented here, the opinion usurps the state legislative function, and in so doing silences the voice of the people of Washington and defies the Supreme Court's call for judicial restraint in the area of substantive due process.[9]

The majority fundamentally errs by resting its holding on obvious distortions of the language in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 112 S. Ct. 2791 (1992), and *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990). As the Second Circuit recently concluded: "The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death." *Quill v. Vacco*, 80 F.3d 716, 724-25 (2d Cir. 1996); *accord Compassion*, 79 F.3d at 857 (Fernandez, J., dissenting) ("no one has an even nonfundamental *constitutional right* to become what our legal ancestors pithily denominated a *felo de se*"); *People v. Kevorkian*, 527 N.W.2d 714, 728 (Mich. 1994) ("We disagree with [the district court in *Compassion*] that either *Cruzan* or *Casey* preordains that the Supreme Court would find that any persons, including the terminally ill, have a liberty interest in suicide that is protected by the Fourteenth Amendment."), *cert. denied*, 115 S. Ct. 1795 (1995).

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[9] *See, e.g., Collins v. City of Harker Heights, Tex.*, 112 S. Ct. 1061, 1068 (1992) ("The doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in [the area of substantive due process].").

A

It is clear that the *Casey* Court upheld the right to abortion more on the basis of *stare decisis* than on a reasoned reaffirmation of the notion that abortion is a protected liberty interest. *See Casey*, 112 S. Ct. 2791, 2817 (joint opinion of Justices O'Connor, Kennedy, and Souter) ("after nearly 20 years of litigation in *Roe's* wake we are satisfied that the immediate question is not the soundness of *Roe's* resolution of the issue, but the precedential force that must be accorded to its holding"). Furthermore, the *Casey* Court *retreated* from the central holding of *Roe*[10] by rejecting the notion that abortion is a fundamental right triggering heightened judicial scrutiny. *See Casey*, 112 S. Ct. at 2855, 2860 (Rehnquist, C.J., dissenting) (describing the joint opinion). Considering the Court's refusal to reaffirm the entire holding of *Roe* on the merits, and in light of the utter lack of any *stare decisis* roots for the right to assisted suicide, it plainly appears that *Casey* is a perniciously thin reed upon which to rest the majority's radical holding.

The majority draws an absurd parallel between a person's decision to enlist a doctor's aid in the termination of her own life and a woman's decision to terminate a pregnancy. The majority grounds this novel marriage of two wholly inapposite situations in the poetic language of *Casey*, in which the Court described an abortion decision as "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 112 S. Ct. at 2807; *see Compassion*, 79 F.3d at 813-14. Engaging in one of the most egregious judicial leaps, the majority discovers a right to assisted suicide by simply concluding that such a right

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[10] *Roe v. Wade*, 410 U.S. 113 (1973).

involves "'one of the most intimate and personal choices a person may make in a lifetime . . . .'" *Compassion*, 79 F.3d at 813-14.

The majority's method of constitutional interpretation lays the foundation for the discovery of an endless parade of protected liberty interests involving choices that could be cast as "intimate" and "personal." If physician-assisted suicide is a protected "intimate and personal choice," why aren't polygamy, consensual duels, prostitution, and, indeed, the use of illicit drugs? Furthermore, if assisted suicide is so clearly protected by the Constitution, why immunize only the physician and those acting under a physician's supervision?[11] Why wouldn't the Constitution also immunize family members or friends who profess compassion for the dying and act without consulting a physician? Indeed, isn't the *Compassion* holding the first tangible step down the very "slippery slope" we were assured *Roe* never authorized?

B

The majority goes on to err by concluding that there is no constitutionally permissible distinction between suicide and refusing medical treatment; such a conclusion ignores a long line of judicial decisions that recognize the distinction.[12] The right to refuse medical treatment is

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[11] *See, e.g.*, Daniel Q. Haney, *Nurses Admit They Hasten Deaths*, Wash. Post, May 23, 1996, at A13 (reporting that survey published in *The New England Journal of Medicine* reveals that one in five intensive-care nurses responding to survey admitted hastening deaths of terminally ill patients, sometimes acting contrary to physician's orders but out of compassion for the patient at the urging of the patient or family members).

[12] *See, e.g., Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (distinguishing an act of intentional self-destruction from "a competent, rational decision to refuse treatment

grounded in the common law right to be free of unwanted bodily contact; in contrast, the common law has never recognized a right to assistance in deliberately taking one's life. The removal of life-support is not the actual cause of death; there, death results from natural causes. *See* Stephen Carter, The Culture of Disbelief 236 (1993)

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when death is inevitable"); *People v. Kevorkian*, 527 N.W.2d 714, 728 (Mich. 1994) ("whereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention"), cert. denied, 115 S. Ct. 1795 (1995); *McKay v. Bergstedt*, 801 P.2d 617, 626 (Nev. 1990) (concluding that there is a difference "between choosing a natural death summoned by an uninvited illness or calamity and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying"); *Matter of Quinlan*, 355 A.2d 647, 665 (N.J.) ("We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support . . . in the face of irreversible, painful and certain imminent death."), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Ct. App. 1986) ("[A] decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting therein."); *see also* New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 71 (May 1994) ("The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity.... It is this right against intrusion - not a general right to control the timing and manner of death - that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.").

("[assisted suicide] involves not *letting* the patient die, but *making* the patient die").

The majority compounds its error by dramatically expanding the narrow holding of *Cruzan*, 110 S. Ct. 2841 (holding that Constitution does not forbid Missouri from requiring clear and convincing evidence of an incompetent's wishes as to the withdrawal of life-sustaining treatment). The *Cruzan* Court merely "assume[d] for purposes of this case" that a competent person does have "a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 2852; *see* 2 Alan Meisel, The Right to Die § 18.22, at 498 (2d ed. 1995) ("the *Cruzan* opinion proceeded on *assumptions*, not holdings, about the rights of competent patients").

In *Cruzan*, the Supreme Court in no way offered support for the recognition of a right to assisted suicide. In fact, the Court not only emphasized that a state has an undeniable interest in the protection and preservation of human life, but also specifically noted that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Id.* at 2852. The hesitancy and narrowness of the *Cruzan* holding should have given the majority pause in its endeavor to recognize a new right under the Due Process Clause; instead, the majority inexplicably heralds the highly limited language of *Cruzan* as a "powerful precedent" in support of the right to assisted suicide.

C

Contrary to the conclusions contained in the majority's lengthy exegesis, neither the Constitution nor history supports the notion that this court may compel the State of Washington (and eight other western states) to recognize an individual's right to physician-assisted suicide.

Considering the pains to which the majority has gone to assert the redemptive nature of Judas Iscariot's suicide and to attribute utilitarian motivations to St. Augustine's writings on suicide,[13] I feel obliged to observe that no amount of historical revisionism can cure the constitutional infirmities that plague the majority's holding. Moreover, the majority's extensive discussion of historical attitudes toward suicide is beside the point; the proper focus should be on whether a right to assisted suicide is rooted in American history and tradition. Clearly it is not. *See, e.g., Cruzan*, 110 S. Ct. at 2859, 2860 (Scalia, J., concurring) ("Case law at the time of the adoption of the Fourteenth Amendment generally held that assisting suicide was a criminal offense."); *Quill*, 80 F.3d at 724 ("Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true.").

The most comprehensive study available on the history of suicide unequivocally concludes that "the weight of authority in the United States, from colonial days through at least the 1970s has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide. It follows that courts should not hold suicide or its assistance to be a protected right under the United States Constitution." Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 100 (1985).[14]

The Supreme Court has never recognized a substantive due process right without first finding that there is a

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[13] *See Compassion*, 79 F.3d at 808 & n.25.

[14] Although the 8-judge opinion contains numerous citations to this study, the opinion is careful to omit any mention of the study's conclusion.

> Knowledge of an undesired consequence does not imply that the actor intends that consequence. A physician who administers pain medication with the purpose of relieving pain, doing his best to avert death, is no murderer, despite his knowledge that as the necessary dosage rises, it will produce the undesired consequence of death.

Compassion, 79 F.3d at 858 (Kleinfeld, J., dissenting). Clearly, *Compassion's* constitutionalization of the right of physicians to prescribe lethal doses for the express purpose of ending the lives of their consenting patients goes far beyond the most aggressive, medically approved pain treatments.

V

The eight-judge majority has not sustained its burden of proving that the Constitution compels a state to recognize, against the will of its people, a right to assisted suicide. However much judges, as individuals, may desire such a right for the terminally ill, we, as judges, are limited by the text of the Constitution and by the Framers' clear intent that the judiciary be "disassociated from direct participation in the legislative process." *See Dennis v. United States*, 341 U.S. 494, 517, 552 (1951) (Frankfurter, J., concurring). In the words of Justice Frankfurter: "Our duty to abstain from confounding policy with constitutionality demands perceptive humility as well as self-restraint in not declaring unconstitutional what in a judge's private judgment is deemed unwise and even dangerous." *Id.* at 552.

The constitutionalization of a right to physician-assisted suicide is nothing short of pure invention--constitutionally untenable and historically unprecedented. It is especially egregious when only eight of the

tradition of protecting that particular interest. Here, there is absolutely no tradition of protecting assisted suicide. Almost all states forbid assisted suicide and some states even permit the use of nondeadly force to thwart suicide attempts. No state has ever accepted consent of the victim as a defense to a charge of homicide. These are the political judgments made by the democratic process; if they are no longer "politically correct," let the legislatures act to change them, not life-tenured judges immune from the voters' reach.

IV

Finally, let no one be beguiled into misconceptions concerning *Compassion's* actual holding; this case is *not* about aggressive pain management.

Long before the eight-judge opinion was issued, pain treatments--such as the injection of morphine--have been legal and well-established in the medical community. *See* American Medical Ass'n, Current Opinions of the Council on Ethical & Judicial Affairs, Code of Medical Ethics § 2.20, at 14 (1992) ("For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death.").

Furthermore, no physician has ever been imprisoned for properly prescribing pain killers. It is common knowledge that physicians, with the tacit consent of the family, may over-medicate for pain with the risk of accelerating death. So long as the primary intention is to lessen pain, there is no danger of imprisonment. As Judge Kleinfeld emphasizes, under these circumstances, there is a fundamental distinction between putting one in harm's way and intending death:

twenty-four active judges on our court can nullify the will of the voters of Washington who rejected a physician-assisted suicide law just five years ago.

I respectfully dissent from this court's improvident refusal to grant rehearing en banc by the full court.

TROTT, Circuit Judge, with whom Circuit Judge O'SCANNLAIN concurs, dissenting from the order rejecting the request for rehearing en banc by the full court.

I

> Liberty is not the mere absence of restraint, it is not a spontaneous product of majority rule, it is not achieved merely by lifting under-privileged classes to power, nor is it the inevitable by-product of technological expansion. It is achieved only by a rule of law.

Jackson, Justice Robert H., The Supreme Court in the American System of Government 76 (1955).

No magician--not David Copperfield, not even Harry Houdini--can produce a rabbit from a hat unless the rabbit is in the hat to begin with. Moreover, if a hat does not contain such an animal, a magician cannot claim that anything he is able to produce from it is in fact a rabbit, no matter how sincere he may be or how great his forensic skills. All of this has something to do with basic physics.

But law may not be physics, as Judge Reinhardt's opinion on behalf of our en banc court demonstrates, because, with all respect, he has in fact succeeded in pulling a nonexistent liberty interest out of thin constitutional air, a liberty interest that certainly does not exist in the document itself. I honestly applaud his splendid effort, which is most skillful and elegant, but

unfortunately his production is not law either, it is simply constitutional sleight of hand. Maybe some of us or even many of us would like to see this rabbit in the hat because we believe it's a nice rabbit--hope is an ever-present temptress in a world of woe--but *we* do not get to change the Constitution any more than we get to change physics. Roger Traynor, the influential former Chief Justice of the California Supreme Court, offered the suggestion that

> "one entrusted with decision . . . must also rise above the vanity of stubborn preconceptions, sometimes euphemistically called the courage of one's convictions. He knows well enough that he must disconnect his own predilections, of however high grade he regards them, which is to say he must bring to his intellectual labors a cleansing doubt of his omniscience. . . ."[1]

Certainly our job is to interpret the Constitution and to apply its principles and purposes in a modern setting, but we must also take great care not to cross over into *rewriting* the Constitution. That profound privilege and right belongs to the People, not to us. This line, of course, has nothing to do with physics, it has to do with our assigned constitutional role in our republican form of government as enshrined in our oath of office. It is a line sometimes fuzzy and one about which reasonable judges might disagree, but as Edmund Burke once said, "Though no man can draw a stroke between the confines of day and night, yet light and darkness are upon the whole tolerably distinguishable."

The jurisprudential significance of this case has far more to do with our role and power as federal judges than

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[1] R. Traynor, "Reasoning in a Circle of Law," 56 Va. L. Rev. 739, 750-51 (1970).

with the merits or desirability of physician-assisted suicide. The issue most deserving of attention is whether we have exceeded our lawful interpretative power to remind the democratic process what it can and cannot do.

II

Passive euthanasia, or letting death run its course, is one thing, and suicide another, but active euthanasia, or permitting one person to kill another--even at that person's competent request--seems massively different. This difference is lost in Judge Reinhardt's approach to this case as reflected in the questionable manner in which he states the issue: whether "there is a constitutionally-protected liberty interest in determining the time and manner of one's own death," or whether there is a "right to die." These alternative statements are at odds with the Supreme Court's admonition that "'[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.'" *Reno v. Flores*, 507 U.S. 292, 302 (1993) (quoting *Collins v. City of Harker Heights*, 503 U.S. 115, 126 (1992)).

The active involvement of a person other than the inchoate decedent cannot be excluded from the statement of the constitutional issue in this case. It is the very involvement of this second person as the agent of death--a state licensed physician no less--that adds a critical and irreducible dimension to the issue, a dimension that does not belong in the wings. To relegate this definitive aspect of the question to a subsidiary phase of the analysis strikes me as analytically unsound. After all, what are we *really* talking about? It is the alleged right to have *another* person end one's own life. My colleague Judge Noonan is correct

when he says that "this case is about the role of physicians in bringing about death."

I note with great interest that this alleged right is derivatively asserted by persons *other* than the now deceased patients themselves, i.e., their doctors; and this observation fuels my belief that the broad level of generality or abstraction at which Judge Reinhardt casts the issue is inappropriate and misleading. In substance, he slips the rabbit into the hat so he can later produce it as though it was there all the time.

The "careful description of the asserted right" called for in *Reno v. Flores* has an important purpose. A certain specificity and accuracy of focus enables us correctly to apply the required analysis to the assertion, and it avoids turning the Constitution into a friendly mirror in which we simply see our own predilections, or just a blank check. Constitutional rights are usually expressed in grand terms, but the terms must not be so broad that they fail to give notice as to what they encompass, especially if no textual language suggests their existence.

Given Judge Reinhardt's broad approach to the Constitution, I suppose he would complement his liberty interest right to die with an equally broad substantive right to live; and that a right to live surely encompasses a right to breath. Does this then become for example, the starting point in all environmental cases involving the trees that produce our atmosphere's oxygen? Are we going to balance logging programs against a liberty interest in life? On the basis of a right to breath, what new rights do I have against threats to the ozone layer? Can I invoke a general right to move against traffic laws? A right to eat against the IRS's attempt to collect taxes? If the substantive due process liberty interest in determining the method of our own death is so weighty, why cannot it be claimed by a

motorcycle rider as a balancing interest against helmet laws? The silliness of these examples is not intended to trivialize the weighty issue of physician-assisted suicide, but to expose the error inherent in casting a legal issue too broadly.

Thus, I believe the majority of the three-judge panel was correct in its statement of the issue as whether there exists "a constitutional *right to aid* in killing oneself." When looked at through *this* prism, the line between interpreting and rewriting is "tolerably distinguishable." Killing someone has usually been regarded as murder, unless done in self-defense, et cetera. Yet all of a sudden, a kind of killing that has traditionally been outlawed--assisted suicide is prohibited in forty-five states plus the District of Columbia--becomes enveloped in a liberty interest protected by the Constitution as a right.

III

Justice White has issued on behalf of the Supreme Court a doctrinal warning we should heed, not just because he said it, but because he is correct:

> The court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights

> deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority. The claimed right pressed on us today falls far short of overcoming this resistance.

Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986).

As well written, as erudite, and as seductive as Judge Reinhardt's opinion is on behalf of his school of constitutional interpretation, it conjures up an illusion with "no cognizable roots in the language or design of the Constitution." As such, and with all respect to the panel, the opinion is a well-intentioned and well-meaning tour de force, but illegitimate nonetheless. What *is* deeply rooted and still prevailing in our traditions is a strong aversion, both moral and legal, against the taking of a life of another. From the earliest days of recorded history, one of our most enduring secular principles has enjoined the killing of a fellow human being. Our Constitution protects life, not death. If assisted euthanasia is to be a protected liberty interest, then let the People put it in the Constitution.

Decisions like this are frequently accompanied by a discussion of the "slippery slope" principle. This case suggests, however, that we are not just on a slippery slope, but in a state of constitutional free fall resulting from what Dean Erwin Griswold called "decisional leapfrogging":

> the first decision is distilled from the language of the Constitution, but the next expansion begins from the reasoning of the last decision, and so on down the line until we reach a point where the words of the Constitution are so far in the background that they are virtually

> ignored. In the end, we may be left with a rationale that comes to little more than, "Well, it really is a good idea. We want a free society where all of these things can be done and we want to keep the Government off the backs of the people." There are governmental processes for bringing such results about, but it is hard to think that such adumbrations of the Constitution are an appropriate exercise of judicial power.[2]

I repeat, again with all respect to the en banc court, their decision has *rewritten* the Constitution, not interpreted it. The supposedly least dangerous branch has usurped the right of the People in a sovereign state to make their own laws, including their right to draft their own Constitution and to decide upon which areas of life the majority shall not trespass. This en banc decision and the manner in which it treats the Constitution and the role of federal judges sounds a sour note in the careful orchestration of our harmonious institutions and our republican form of government. Shorn of its Corinthian decor, it is nothing less than an act of judicial imperialism of the very kind that threatened the independence of the Supreme Court in the 1930's. When we face political questions in legal form, we must give legal answers, not political ones.

The decisions made by the legislative organs of our government are not always to our liking. In fact, some of us on occasion may think they are abhorrent. Some values possibly should be in our Constitution, but are not. But what sets us apart from other forms of government is our belief in process. We are a nation of laws, not of leaders. Whenever we override democratic choice as we have done

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[2] Erwin N. Griswold, "The Judicial Process." 31 Fed. B.J. 309, 317 (1972).

here, we are just a naked power organ unless our warrant to do so manifests itself in the Constitution. The right to assisted euthanasia does not, not in the text of the original document or its interstices, not in the thinking or purpose of those who drafted the Fourteenth Amendment, and not in our traditions, customs, or history. Not a word supporting the existence of this "right" can be found in the records of any of the recognized sources of constitutional illumination.

If this supposed liberty interest cannot be found in any of these sources or anywhere in *our* history or traditions, where else is there to look? Where does this amorphous approach to substantive due process rights end? The majority opinion reads like a celebration of "natural law." Judge Reinhardt's revealing use of the Harris poll and the Roper Report as a source of constitutional enlightenment strikes me as particularly inappropriate. The Constitution's explicit provisions for amendment rely on government process, not on random sampling of public opinion. Polls are for the other branches of our government, not for the judiciary. Equally irrelevant is his observation that a retired Justice Powell said he probably made a mistake in *Bowers v. Hardwick*.

No matter where we stand on the range of our interpretive power, the supreme function of a judge is to recognize that there must be limits to our writ. Even those celebrated advocates of sociological jurisprudence who delivered us from the grip of the 19th century's rigidly mechanical approach to the law recognized clear limits to their authority as jurists. Justice Oliver Wendell Holmes, for example, said, "I recognize without hesitation that judges do and must legislate, but they only do so

interstitially; they are confined from molar to molecular motions."[3] Justice Benjamin Cardozo put it this way:

> "[A judge] is not a knight-errant, roaming at will in pursuit of his own ideal of beauty or of goodness. . . . He is not to yield to spasmodic sentiment, to vague and unregulated benevolence." . . . "Judges have . . . the power, though not the right to travel beyond the walls of the interstices, the bounds set to judicial innovation by precedent and custom. Nonetheless, by that abuse of power, they violate the law."[4]

Even more appropriate for a controversial polycentric issue involving the active taking by a state licensed medical doctor of the life of a gravely ill yet somehow competent person are the words of Justice William O. Douglas:

> The changes suggested implicate so many policies and raise so many problems of a political, economic, and social nature that it is fit that the Judiciary recuse itself. At times judges must legislate "interstitially" to resolve ambiguities in laws. But the problem of taking all or some alien commuters engaged in farm work out of the Act is not "interstitial" or as Mr. Justice Holmes once put it "molecular." It is a massive or "molar" action for which the judiciary is ill-equipped.[5]

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[3] *Southern Pacific Co. v. Jensen*, 244 U.S. 205 (1917) (Holmes, J., dissenting).

[4] Benjamin N. Cardozo, "The Nature of the Judicial Process," 129, 141 (1921).

[5] *Saxbee v. Bustos*, 419 U.S. 65, 79-80 (1974).

If the only limit on our authority is the grand eloquence of our rhetoric, then we live by fiat of the judiciary. Dean Griswold called this, "Justice as administered by Harun al Rashid sitting under a tree. As Cardozo said, 'That might result in a benevolent despotism if the Judges were benevolent [people].'"[6] As Francis Bacon said in 1625, "This office is *jus dicere*, not *jus dare*, to interpret law, and not to make law or to give law." Francis Bacon, Of Judicature, in Essays Civil and Moral (58 Murphy's ed. 1826) (1625). If the difference is not tolerably discernible, trouble may become our middle name. Is our independence at stake? Archibald Cox gave us his answer to this question in 1987, an answer that may partially explain the Senate's aggressive approach to judicial confirmation hearings:

> The style of constitutional interpretation and the traditional independence of the judiciary from political pressure and responsibility are interrelated. If the process of decision making is excessively politicized, there will be additional pressure to choose judges who will cast their votes on grounds of policy. Such choices, in turn, would make the style of decision making still more political, in both fact and public perception. The heightened perception would fuel still further demand. The cycle would inevitably lead to demands for the election of justices and judges. If the key court decisions are little different from the determinations of policy by other branches of govern-

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[6] Erwin N. Griswold, "The Judicial Process." 31 Fed. B.J. 309 (1972).

> ment, why should not the voters elect the justices and judges for terms of years?[7]

As Judge Learned Hand said,

> [The judge's] authority and immunity depend upon the assumption that he speaks with the mouth of others: The momentum of his utterance must be greater than any which his personal regulation and character can command, if it is to stand against the passionate resentments arising out of the interests he must frustrate.[8]

As did the framers, I prefer Justice Jackson's liberty of law to the protection of a benevolent dictator or a monarch, or of an unbridled federal judiciary where sooner or later power corrupts, and . . . you know the rest. I have the greatest admiration for my friend Judge Reinhardt and for the en banc court majority, able and dedicated jurists all, but on this issue, I respectfully disagree with their approach and their judgment. *We* have an obligation to undue this mistake, not to expect the Supreme Court to clean up our excesses.

Thus, I respectfully dissent from our decision not to rehear this landmark case sitting as a full court en banc.[9]

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[7] Archibald Cox, "The Court and the Constitution" (1987).

[8] L. Hand, *Mr. Justice Cardozo*, 52 Harv. L. Rev. 361 (1939).

[9] I am indebted to our colleague Ruggero J. Aldisert and to his new book "The Judicial Process" (Second Edition) as a source of education and inspiration.

APPENDIX D

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

COMPASSION IN DYING, a Washington nonprofit corporation; JANE ROE; JOHN DOE; JAMES POE, HAROLD GLUCKSBERG, M.D.,
Plaintiffs-Appellees,

v.

STATE OF WASHINGTON; CHRISTINE GREGOIRE, Attorney General of Washington,
Defendants-Appellants.

No. 94-35534
D.C. No. CV-94-00119-BJR
OPINION

Appeal from the United States District Court
for the Western District of Washington
Barbara J. Rothstein, Chief District Judge, Presiding

Argued and Submitted
December 7, 1994—Seattle, Washington

Filed March 9, 1995

Before: Eugene A. Wright, John T. Noonan, Jr., and Diarmuid F. O'Scannlain, Circuit Judges.

Opinion by Judge Noonan; Dissent by Judge Wright.

SUMMARY

Individual Rights/Constitutional Rights/Privacy

The court of appeals reversed a district court judgment. The court held that there was no basis for concluding that a Washington state statute that criminalizes promoting a suicide attempt violates the United States Constitution.

A Washington state statute states that a person is guilty of the felony of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide. Appellee Compassion in Dying, three now-deceased individuals who were suffering from diseases, and four physicians asserting their own rights and those of their patients, sued appellant the State of Washington, seeking a declaration that the statute violated 42 U.S.C. § 1983 and the Constitution of the United States. They also asked that enforcement of the statute be enjoined.

On motions for summary judgment, the district court denied the motion of the physicians asserting their own claims and denied Compassion's claim on its own behalf. The court, however, granted the motion for summary judgment of the now-deceased individuals and the similar motion of the physicians on behalf of their "terminally ill patients." The court declined to enjoin enforcement of the statute, but declared the statute to violate the Constitution of the United States. The court held that the statute violated the liberty guaranteed by the Fourteenth Amendment against deprivation by a state. The court quoted a Supreme Court case concerning abortion. *Planned Parenthood v. Casey*, in which the Court stated that "choices central to personal dignity and autonomy" are "central to the liberty protected by the Fourteenth

Amendment." The court also quoted a Supreme Court case, *Cruzan v. Director, Missouri Dept. of Health*, in which, the Court referred to the recognition of a "general liberty interest in refusing medical treatment." The court concluded that there was a constitutional right to physician-assisted suicide. The court further stated that the "total ban" on physician-assisted suicide for the terminally ill was "an undue burden" on the constitutional right, and consequently the statute was invalid. The court also held that the statute violated the Equal Protection Clause, seeing no constitutional distinction between the terminally ill able to direct the withdrawal or withholding of life support and the terminally ill seeking medical aid to end their lives. The State appealed.

[1] The district court's conclusion that the statute deprived the plaintiffs of a liberty protected by the Fourteenth Amendment and denied them equal protection of the laws could not be sustained. [2] The language taken from *Casey* was not to be removed from the context in which it was uttered. [3] Furthermore, the district court's decision lacked foundation in recent precedent and in the traditions of our nation. [4] The facial invalidation of the statute was wholly unwarranted; the district court conceded that there were circumstances in which the statute could operate constitutionally. [5] The district court declared the statute unconstitutional on its face without adequate consideration of the State's interests that, individually and convergently, outweigh any alleged liberty of suicide. [6] The state had interests in not having physicians in the role of killers of their patients; [7] not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths; [8] protecting the poor and minorities from exploitation; [9] protecting all of the handicapped from societal indifference and antipathy; [10] preventing abuse similar to what has occurred in the

Netherlands where legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient. [11] In addition, the scope of the district court's judgment was indefinite; [12] one could only guess which definition of the "terminally ill" would satisfy the constitutional criteria of the district court; an amorphous class of beneficiaries was created in a non-class action. [13] Finally, at the heart of the district court's decision appeared to be its refusal to distinguish between actions taking life and actions by which life is not supported or ceases to be supported; however, the plaintiffs did not show that the distinction drawn by the legislature was irrational.

Circuit Judge Wright dissented, stating that the Washington statute violates the plaintiffs' privacy and equal protection rights.

-COUNSEL-

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Wesley J. Smith, San Francisco, California, for amicus curiae International Anti-Euthanasia Task Force.

Katrin E. Frank, Robert A. Free, Kathleen Wareham, MacDonald, Hoague & Bayless, Seattle, Washington, for amicus curiae Ten Surviving Family Members.

James Bopp, Jr., Thomas J. Marzen, Daniel Avila, John Altomare, Jane E.T. Brockmann, National Legal Center for the Medically Dependent and Disabled, Inc., Indianapolis, Indiana, as amicus curiae.

John R. Reese, Robert A. Lewis, Page R. Barnes, Amy J. Metzler, Holly Morris, McCutchen, Doyle, Brown & Enersen, San Francisco, California, for amicus curiae Americans for Death with Dignity.

Mary D. Clement, Junction City, Oregon, for amicus curiae Euthanasia Research & Guidance Organization.

Mark E. Chopko, Michael F. Moses, Washington, D.C., for amicus curiae United States Catholic Conference.

Paul Benjamin Linton, Clarke D. Forsythe, Chicago, Illinois, for amicus curiae Americans United for Life.

Barbara Allan Shickich, Joseph E. Shickich, Jr., Riddell, Williams, Bullitt & Walkinshaw, Seattle, Washington, for amicus curiae Washington State Hospital Association and Catholic Health Association of the United States.

Catherine W. Smith, Edwards, Sieh, Wiggins & Hathaway, Seattle, Washington, for amicus curiae Amici State Legislators.

Todd Maybrown, Allen, Hansen & Maybrown, Seattle, Washington, for amici curiae the American Civil Liberties Union of Washington, the Northwest Women's Law Center, Lambda Legal Defense and Education Fund, Inc., AIDS Action Council, the Northwest AIDS Foundation, the Seattle AIDS Support Group, the Gray Panthers Project Fund, the Older Women's League, the Seattle Chapter of the National Organization for Women, the American Humanist Association, the National Lawyers Guild, Local 6 of Service Employees International Union, Temple De Hirsch Sinai, the Unitarian Universalist Association, the Seattle Chapter and the Pacific Northwest District Council of the Japanese American Citizens League.

Kirk B. Johnson, Michael L. Ile, David Orentlicher, Chicago, Illinois; Jack R. Biering, Sidley & Austin, Chicago, Illinois; Paul E. Kalb, Sidley & Austin,

Washington, D.C., for amicus curiae American Medical Association.

OPINION

NOONAN, Circuit Judge:

The State of Washington (Washington) appeals the decision of the district court holding unconstitutional Washington's statute on promoting a suicide attempt. Finding no basis for concluding that the statute violates the Constitution, we reverse the district court.

The Statute

The challenged statute reads as follows:

> Promoting a suicide attempt
>
> (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.
>
> (2) Promoting a suicide is a Class C felony. Wash. Rev. Code 9A.36.060.

The Plaintiffs

Compassion in Dying is a nonprofit incorporated in the state of Washington. Its avowed purpose is to assist persons described by it as "competent" and "terminally ill" to hasten their deaths by providing them information, counselling, and emotional support but not by administering fatal medication.

Three individuals were plaintiffs in their own right. Their identities are cloaked by an order permitting them to litigate under pseudonyms. They are now deceased. Jane Roe was a 69-year-old physician, suffering from cancer; she had been bedridden for seven months at the time the

suit was brought and died before judgment was entered by the district court. John Doe was a 44-year-old artist, who was partially blind at the time of suit and was also suffering from AIDS; he had been advised that his disease was incurable; he died prior to judgment. James Poe was a 69-year-old patient suffering from chronic obstructive pulmonary disease; he was connected to an oxygen tank at all times. He died after judgment but prior to the hearing of this appeal.

Four physicians also joined the suit asserting their own rights and those of their patients. Harold Glucksberg has specialized in the care of cancer since 1985 and is a clinical assistant professor at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" encounters patients whom he believes he should assist in terminating their lives, but does not because of the statute; he refers to two such patients, both deceased. Abigail Halpern is the medical director of Uptown Family Practice in Seattle and serves as a clinical faculty member at the University of Washington School of Medicine. In her practice, according to her sworn declaration, she "occasionally" treats patients dying of cancer or AIDS, whose death she believes she should hasten but does not because of the statute; she refers to one such patient, now deceased. Thomas A. Preston is chief of cardiology at Pacific Medical Center in Seattle and professor of Medicine at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" treats patients whose death he believes he should hasten but does not on account of the statute; he refers to one such patient, now deceased. Peter Shalit is in private practice in Seattle and the medical director of the Seattle Gay Clinic; he is a clinical instructor at the University of Washington School of Medicine. According to his sworn declaration, he "occasionally" treats patients

whose death he believes he should hasten, but does not on account of the statute; he refers to one such patient, now deceased.

PROCEEDINGS

On January 29, 1994, the plaintiffs brought suit against Washington, seeking a declaration that the statute violated 42 U.S.C. § 1983 and the Constitution of the United States; additionally, they asked that enforcement of the statute be enjoined.

The plaintiffs introduced the declarations of the physicians already noted, together with declarations from the executive director of Compassion in Dying and from Jane Roe, John Doe, and James Poe. They also introduced the sworn declaration of John P. Geyman, who had served from 1976 through 1990 as professor and chairman of the Department of Family Medicine at the School of Medicine of the University of Washington and is now engaged in rural practice at Friday Harbor. According to him, there is "often a severe adverse emotional and psychological effect" on patients unable because of the statute to broach the subject of their desire to hasten their deaths or who do broach the subject and are rebuffed.

The plaintiffs moved for summary judgment, and the defendants made a cross-motion for summary judgment. On May 3, 1994, the district court ruled on these motions. It denied the motion of the four physician plaintiffs asserting their own claims "on the grounds that the basis for those claims has not been adequately addressed." It denied Compassion in Dying's claim on its own behalf "for the same reason." It denied the cross-motion of Washington. It granted the motion for summary judgment of Jane Roe, John Doe and James Poe and the similar motion of the physician plaintiffs "on behalf of their terminally ill patients." The court declined to enjoin

enforcement of the statute but declared the statute to violate the Constitution of the United States.

The district court reached its conclusion as to unconstitutionality on two grounds. First, the court held that the statute violated the liberty guaranteed by the Fourteenth Amendment against deprivation by a state. The court reached this conclusion by noting "a long line of cases" protecting "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education." The court quoted as the explanation of this line the statement made in *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992): "These matters, including the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."

The district court analogized the "terminally ill person's choice to commit suicide" to the choice of abortion protected by *Casey*, stating: "this court finds the reasoning in *Casey* highly instructive and almost prescriptive." Like the abortion decision, the court found the decision by a terminally ill person to end his or her life to be one of the most intimate and personal that could be made in a lifetime and a choice central to personal autonomy and dignity.

The district court also found *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) to be "instructive." It quoted that case's reference to "the recognition of a general liberty interest in refusing medical

treatment," *Cruzan* at 278, and the assumption for purposes of the decision in *Cruzan* "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. The district court stated that it did not believe that a distinction of constitutional significance could be drawn "between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult." Combining its exegesis of *Casey* and *Cruzan*, the district court reached its conclusion that there was a constitutional right to physician-assisted suicide.

The district court then reviewed the statute to determine whether, on its face, it imposed an "undue burden " on a personal right of the *Casey* kind. *See Casey* at 2830 (concluding that a statute regulating abortion was invalid on its face because "in a large fraction of the cases" in which the statute would operate it would "operate as a substantial obstacle to a woman's choice to undergo an abortion" and therefore placed "an undue burden"). The district court declared that there was "no question" that the "total ban" on physician-assisted suicide for the terminally ill was "an undue burden" on the constitutional right that the district court had discovered. Consequently, the statute was invalid.

Secondly, the district court held that the statute violated the Equal Protection Clause of the Fourteenth Amendment, requiring that all similarly situated persons be treated alike. Washington law, enacted in 1992, provides: "Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition." Wash. Rev. Code 70.122.030. Any physician who participates in good faith "in the withholding or withdrawal of life-sustaining treatment" in accordance with such a

directive is immune from civil or criminal or professional liability. *Id.* 70.122.051. The district court could see no constitutional distinction between the terminally ill able to direct the withdrawal or withholding of life support and the terminally ill seeking medical aid to end their lives. Accordingly, it found an unequal application of the laws.

Washington appeals.

ANALYSIS

[1] The conclusion of the district court that the statute deprived the plaintiffs of a liberty protected by the Fourteenth Amendment and denied them the equal protection of the laws cannot be sustained.

[2] *First.* The language taken from *Casey*, on which the district court pitched its principal argument, should not be removed from the context in which it was uttered. Any reader of judicial opinions knows they often attempt a generality of expression and a sententiousness of phrase that extend far beyond the problem addressed. It is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context. To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these sentences "almost prescriptive" in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request.

The inappropriateness of the language of *Casey* in the situation of assisted suicide is confirmed by considering what this language, as applied by the district court, implies. The decision to choose death, according to the district court's use of *Casey*'s terms, involves "personal dignity

and autonomy" and "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." The district court attempted to tie these concepts to the decision of a person terminally ill. But there is no way of doing so. The category created is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every same adult. The attempt to restrict such rights to the terminally ill is illusory. If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it. See Yale Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" 23 *Hastings Center Report* 32, 36-37 (1995). The conclusion is a *reductio ad absurdum*.

Second. While *Casey* was not about suicide at all, *Cruzan* was about the termination of life. The district court found itself unable to distinguish between a patient refusing life support and a patient seeking medical help to bring about death and therefore interpreted *Cruzan*'s limited acknowledgment of a right to refuse treatment as tantamount to an acceptance of a terminally ill patient's right to aid in self-killing. The district court ignored the far more relevant part of the opinion in *Cruzan* that "there can be no gainsaying" a state's interest "in the protection and preservation of human life" and, as evidence of that legitimate concern, the fact that "the majority of States in this country have laws imposing criminal penalties on one

who assists another to commit suicide." *Cruzan*, 497 U.S. at 280. Whatever difficulty the district court experienced in distinguishing one situation from the other, it was not experienced by the majority in *Cruzan*.

[3] *Third*. Unsupported by the gloss on "liberty" written by *Casey*, a gloss on a gloss, inasmuch as *Casey* developed an interpretation of "liberty" first elaborated in *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), and implicitly controverted by *Cruzan*, the decision of the district court lacks foundation in recent precedent. It also lacks foundation in the traditions of our nation. *See Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (Cardozo, J.); *Lochner v. New York*, 198 U.S. 45, 76 (1905) (Holmes, J., dissenting). In the two hundred and five years of our existence no constitutional right to aid in killing oneself has ever been asserted and upheld by a court of final jurisdiction. Unless the federal judiciary is to be a floating constitutional convention, a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life that has been a chief responsibility of our constitutional government.

[4] *Fourth*. The district court extrapolated from *Casey* to hold the statute invalid on its face. That extrapolation, like the quotation from *Casey*, was an unwarranted extension of abortion jurisprudence, often unique, to a very different field. The normal rule -- the rule that governs here -- is that a facial challenge to a statute "must establish that no set of circumstances exists under which the Act would be valid." *United States v. Salerno*, 481 U.S. 739, 745 (1987). The district court indeed conceded that there were circumstances in which the statute could operate constitutionally, for example to deter suicide by teenagers or to prevent fraud upon the elderly. The district court did not even attempt the calculation carried out in *Casey* to show that in "a large fraction of the cases" the statute

would operate unconstitutionally. From the declarations before it the district court had at most the opinion of several physicians that they "occasionally" met persons whom the statute affected detrimentally and their recitation of five case histories. There was no effort made to compare this number with the number of persons whose lives were guarded by the statute. The facial invalidation of the statute was wholly unwarranted.

[5] *Fifth.* The district court declared the statute unconstitutional on its face without adequate consideration of Washington's interests that, individually and convergently, outweigh any alleged liberty of suicide. The most comprehensive study of our subject by a governmental body is *When Death Is Sought. Assisted Suicide and Euthanasia in the Medical Context* (1994). The study was conducted by the New York State Task Force, a commission appointed by Governor Cuomo in 1985, which filed its report in May, 1994. The Task Force was composed of twenty-four members representing a broad spectrum of ethical and religious views and ethical, health, legal, and medical competencies. Its membership disagreed on the morality of suicide. Unanimously the members agreed against recommending a change in New York law to permit assisted suicide. Washington's interest in preventing such suicides is as strong as the interests that moved this diverse commission to its unanimous conclusion. A Michigan commission, set up in 1992, by majority vote in June 1994 recommended legislative change in the Michigan law against assisted suicide and set out a proposed new statute as a legislative option; the commission did not challenge the constitutionality of the existing Michigan legislation. Michigan Commission on Death and Dying, *Final Report* (1994). Neither the New York nor the Michigan reports were available to the district court. We take them into account on this appeal as we take

into account the legal and medical articles cited by the parties and amici as representative professional judgments in this area of law. In the light of all these materials, Washington's interests are at least these:

[6] 1. The interest in not having physicians in the role of killers of their patients. "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer," declares the American Medical Association's *Code of Medical Ethics* (1994) § 2.211. From the Hippocratic Oath with its promise "to do no harm," *see* T.L. Beauchamp and J.F. Childress, *Principles of Biomedical Ethics* (1993) 330, to the AMA's code, the ethics of the medical profession have proscribed killing. Washington has an interest in preserving the integrity of the physician's practice as understood by physicians.

Not only would the self-understanding of physicians be affected by removal of the state's support for their professional stance; the physician's constant search for ways to combat disease would be affected, if killing were as acceptable an option for the physician as curing. *See* Alexander M. Capron, "Euthanasia in the Netherlands: American Observations," 22 *Hastings Center Report* 30, 32 (1992). The physician's commitment to curing is the medical profession's commitment to medical progress. Medically-assisted suicide as an acceptable alternative is a blind alley; Washington has a stake in barring it.

[7] 2. The interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths. For all medical treatments, physicians decide which patients are the candidates. If assisted suicide was acceptable professional practice, physicians would make a judgment as to who was a good candidate for it. Physician neutrality and patient autonomy, independent of their physician's advice, are largely myths.

Most patients do what their doctors recommend. As an eminent commission concluded, "Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation." New York State Task Force, *When Death Is Sought*, 122. Washington has an interest in preventing such persuasion.

[8] 3. The interest in protecting the poor and minorities from exploitation. The poor and minorities would be especially open to manipulation in a regime of assisted suicide for two reasons: Pain is a significant factor in creating a desire for assisted suicide, and the poor and minorities are notoriously less provided for in the alleviation of pain. *Id.* at 100. The desire to reduce the cost of public assistance by quickly terminating a prolonged illness cannot be ignored: "the cost of treatment is viewed as relevant to decisions at the bedside." *Id.* at 129. Convergently, the reduction of untreated (although treatable) pain and economic logic would make the poorest the primest candidates for physician-assisted and physician-recommended suicide.

[9] 4. The interest in protecting all of the handicapped from societal indifference and antipathy. Among the many briefs we have received from amici curiae there is one on behalf of numerous residents of nursing homes and long-term care facilities. The vulnerability of such persons to physician-assisted suicide is foreshadowed in the discriminatory way that a seriously-disabled person's expression of a desire to die is interpreted. When the nondisabled say they want to die, they are labelled as suicidal; if they are disabled, it is treated as "natural" or "reasonable". *See* Carol J. Gill, "Suicide Intervention for Persons with Disabilities: A Lesson in Inequality," 8 *Issues in Law & Med.* 37, 38-39 (1993). In the climate of our achievement-oriented society, "simply offering the option of 'self-

deliverance' shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it." Richard Doerflinger, "Assisted Suicide: Prochoice or Anti-Life?" 19 *Hastings Center Report* 16, 17 (1989). An insidious bias against the handicapped -- again coupled with a cost-saving mentality -- makes them especially in need of Washington's statutory protection.

[10] 5. An interest in preventing abuse similar to what has occurred in the Netherlands where, since 1984, legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient. In 1990, approximately 1.8 per cent of all deaths resulted from this practice. At least an additional .8 percent of all deaths, and arguably more, come from direct measures taken to end the person's life without a contemporaneous request to end it. New York State Task Force, *When Death Is Sought*, 133-134.

[11] Sixth. The scope of the district court's judgment is, perhaps necessarily, indefinite. The judgment of the district court was entered in favor of Jane Roe and John Doe although they were dead. This unheard-of judgment was a nullity. The judgment in favor of James Poe lapsed with his death pending appeal. The judgment in favor of Doctors Glucksberg, Halperin, Preston and Shalit was "insofar as they raise claims on behalf of their terminally ill patients." No such patients were identified by these doctors except patients who were already deceased. Presumably, then, the judgment was behalf of terminally ill patients that these doctors might encounter in the future. The term "terminally ill" was not defined by the court. No class was certified by the court. There is a good deal of uncertainty on whose behalf the judgment was entered.

[12] It was suggested in argument that a definition of the terminally ill could be supplied from the Washington

statute on the refusal of life-sustaining treatment which does define "terminal condition." Wash. Rev. Code 70.122.020(9). There are three difficulties: "terminal condition" and "terminally ill" are different terms; the examples given by the plaintiffs show considerable variation in wnom they considered terminally ill to be; there is wide disagreement in definition of the terminally ill among the states. See New York State Task Force, *When Death Is Sought*, 23-35. Life itself is a terminal condition, unless terminal condition is otherwise defined by a specific statute. A terminal illness can vary from a sickness causing death in days or weeks to cancer, which Dr. Glucksberg notes is "very slow" in its deadly impact, to a heart condition which Dr. Preston notes can be relieved by a transplant, to AIDS, which Dr. Shalit declares is fatal once contracted. One can only guess which definition of the terminally ill would satisfy the constitutional criteria of the district court. Consequently, an amorphous class of beneficiaries has been created in this non-class action; and the district court has mandated Washington to reform its law against the promotion of suicide to safeguard the constitutional rights of persons whom the district court has not identified.

[13] Seventh. At the heart of the district court's decision appears to be its refusal to distinguish between actions taking life and actions by which life is not supported or ceases to be supported. This refusal undergirds the district court's reading of *Cruzan* as well as its holding that the statute violates equal protection. The distinction, being drawn by the legislature not on the basis of race, gender or religion or membership in any protected class and not infringing any fundamental constitutional right, must be upheld unless the plaintiffs can show "that the legislature's actions were irrational." *Kadrmas v. Dickerson Public Schools*, 487 U.S. 450, 458 (1988). The plaintiffs have not sustained this burden.

Against the broad background of moral experience that everyone acquires, the law of torts and the law of criminal offenses against the person have developed. "At common law, even the touching of one person by another without consent and without legal justification was a battery." *Cruzan*, 497 U.S. at 269. The physician's medical expertness is not a license to inflict medical procedures against your will.

Protected by the law of torts, you can have or reject such medical treatment as you see fit. You can be left alone if you want. Privacy in the primordial sense in which it entered constituted parlance -- "the right to be let alone" -- is yours. *See Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

Tort law and criminal law have never recognized a right to let others enslave you, mutilate you, or kill you. When you assert a claim that another -- and especially another licensed by the state -- should help you bring about your death, you ask for more than being let alone; you ask that the state, in protecting its own interest, not prevent its licensee from killing. The difference is not of degree but of kind. You no longer seek the ending of unwanted medical attention. You seek the right to have a second person collaborate in your death. To protect all the interests enumerated under Fifth above, the statute rightly and reasonably draws the line.

Compassion, according to the reflections of Prince Myshkin, is "the most important, perhaps the sole law of human existence." Feodor Dostoevsky, *The Idiot*, 292 (Alan Myers, trans.) (1991). In the vernacular, compassion is trumps. No one can read the accounts of the sufferings of the deceased plaintiffs supplied by their

declarations, or the accounts of the sufferings of their patients supplied by the physicians, without being moved by them. No one would inflict such sufferings on another or want them inflicted on himself; and since the horrors recounted are those that could attend the end of life anyone who reads of them must be aware that they could be attendant on his own death. The desire to have a good and kind way of forestalling them is understandably evident in the declarations of the plaintiffs and in the decision of the district court.

Compassion is a proper, desirable, even necessary component of judicial character; but compassion is not the most important, certainly not the sole law of human existence. Unrestrained by other virtues, as *The Idiot* illustrates, it leads to catastrophe. Justice, prudence, and fortitude are necessary too. Compassion cannot be the compass of a federal judge. That compass is the Constitution of the United States. Where, as here in the case of Washington, the statute of a state comports with that compass, the validity of the statute must be upheld.

For all the foregoing reasons, the judgment appealed from is REVERSED.

WRIGHT, Circuit Judge, Dissenting:

This case involves the state's power arbitrarily to deprive terminally ill, mentally competent adults of the right to choose how to die. Because RCW 9A.36.060 violates plaintiffs' privacy and equal protection rights, I dissent. The majority's approach subjects such patients to unwanted and needless suffering. *See* Brief of *Amicus Curiae* of Ten Surviving Family Members In Support of Physician-Assisted "Suicide."

The majority views the asserted right as illimitable because it depends upon the meaning of "terminally ill."[1] But if we were to affirm, our task would not be to specify the parameters of the right. We are limited, as was the district court, to the dispute before us. The majority's "depressed twenty-one year old" is not a party before us.[2] The deceased plaintiff patients were terminally ill, mentally competent adults, entitled to be free from unwarranted state interference in their last days.

A. *Due Process*

1. Privacy Right

Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992), defines the scope of protected liberty interests. The Court there explained that:

> [M]atters [ ] involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected

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[1] A federal district court that recently decided against recognizing the asserted right did not have such definitional concerns. *Quill v. Koppell*, 870 F. Supp. 78, 84 (S.D.N.Y. 1994) ("Plaintiffs are, of course, suggesting a limited form of physician assisted suicide.").

[2] In any event, the state has a legitimate interest in preserving the life of a "depressed twenty-one year old" because he or she has a significant life expectancy while the terminally ill plaintiffs before the court had only a limited amount of life left. The state's interest in preserving life declines and the individual's right to privacy grows as natural death approaches. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976). For a complete discussion of the state's interest in preserving the lives of non-terminally ill adults see Robert Sedler, *Constitutional Challenges to Bans on "Assisted Suicide": The View From Without and Within*, 21 Hastings Const. L.Q. 777, 790-795 (1994); Robert L. Risley, *Ethical & Legal Issues in the Individual's Right to Die*, 20 Ohio N.U. L. Rev. 597, 610 (1993).

> by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id. at 2807. The majority contends that this language is out of context in this case. Yet that general language was not tailored specifically for the abortion context but derived from well-established Supreme Court precedent. The same paragraph explains:

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education.

Id. (citation omitted).

The district court's application of *Casey* hardly amounts to "an enormous leap" that does "violence to the context."

An aspect of the liberty interest is the right to personal privacy, or a guarantee of certain areas or zones of privacy. *Carey v. Population Servs. Int'l*, 431 U.S. 678, 684 (1977) (quotation omitted). This privacy right includes "the interest in independence in making certain kinds of important decisions." *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977).

The right to die with dignity falls squarely within the privacy right recognized by the Supreme Court. The decision by a terminally ill, mentally competent adult to request physician assistance in hastening death is a highly personal one, directly implicating the right to privacy. The Supreme Court recognized that "[t]he choice between life and death is a deeply personal decision." *Cruzan v.*

Director, Missouri Dept. of Health, 497 U.S. 261, 281(1990). The Court declared that the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. *Accord In re Quinlan*, 355 A.2d 647, 663 (N.J. 1976) (privacy right "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances."); *Superintendent v. Saikewicz*, 370 N.E.2d 417, 424 (Mass. 1977).

A constitutional distinction cannot be drawn between refusing life-sustaining medical treatment and accepting physician assistance in hastening death.[3] "[I]f an individual has a constitutionally protected right to refuse lifesaving medical treatment and life sustaining nutrition, it would seem logically impossible to make it a crime for that person to take active steps to terminate his life." 3 Rotunda & Nowak, Treatise on Constitutional Law 388 (1992).[4] Such a distinction yields patently unjust results.

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[3] Contrary to the majority's assertion, the *Cruzan* Court did not draw such a distinction. The majority lifts language from *Cruzan* that indicates only that states have a general interest in prohibiting the assistance of suicide. This begs the question whether a state can prohibit physician-hastened death for terminally ill, mentally competent adults.

[4] Indeed, as Justice Scalia framed the problem in his concurring opinion in *Cruzan*: "Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned; the cause of death in both cases is the suicide's conscious decision to put an end to his own existence. Of course the common law rejected the action-inaction distinction in other contexts involving the taking of human life as well. . . . A physician . . . could be criminally liable for failure to provide care that could have extended the patient's life, even if death was immediately caused by the underlying disease that the physician failed to treat." 497 U.S. at 296-97

For example, a respirator-dependent patient may demand that the respirator be removed when the pain becomes unbearable. Terminally ill patients not dependent on such life support, however, cannot receive physician assistance to end unwanted agony. So says the majority opinion.

Along with established precedent, "this Nation's history and tradition" help to define the content of substantive due process. *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977). Because medicine is constantly evolving and presenting new legal questions,[5] whether American history and tradition support the right asserted must be answered at a more abstract level than the majority would permit. For example, in *Loving v. Virginia*, 388 U.S. 1, 12 (1967), the Court looked beyond the historical and traditional bars to interracial marriages to the more abstract principles of the "rights essential to the orderly pursuit of happiness by free men."

Likewise, we must ask whether American history and tradition reflect the values of self-determination and privacy regarding personal decisions. In the late nineteenth century, the Court wrote: "No right is held more sacred, or is more carefully guarded, by the common law, than the

(quotations and citations omitted). *See also* James Rogers, *Punishing Assisted Suicide: Where Legislators Should Fear to Tread*, 20 Ohio N.U. L. Rev. 647, 650 (1993) (explaining impossibility of distinguishing between letting die and assistance in death).

[5] "With the development of the new techniques, serious questions as to what may constitute acting in the best interests of the patient have arisen." *Superintendent v. Saikewicz*, 370 N.E.2d 417, 423 (Mass. 1977). "An inadvertent and unintended side effect of medicine's growing effectiveness is that the dying process has been elongated. . . . [F]or those who are suffering greatly . . . it has become harder and harder to die." Timothy E. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* 50 (1993).

right of every individual to the possession and control of his own person, free from all restraint or interference ofothers unless by clear and unquestioned authority of law." *Union Pac. R. Co. v. Botsford*, 141 U.S. 250 (1891). The right to die with dignity accords with the American values of self-determination and privacy regarding personal decisions.

2. Standard of Review

The applicable standard of review is strict scrutiny.[6] Because a fundamental right is involved, the statute that limits this right can be justified only by a "compelling state interest," *Shapiro v. Thompson*, 394 U.S. 618, 634 (1969), and it must be narrowly drawn to serve only that interest. *Aptheker v. Secretary of State*, 378 U.S. 500, 508 (1964).

3. The Statute is Invalid as Applied

The state has an interest in preserving the lives of its citizens. But the state's interest weakens and the individual's right to privacy grows as natural death approaches. *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976); *Superintendent v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977) (rational decision by terminally ill, competent patient to refuse life-sustaining treatment has no connection with state interest in preserving life).

The Washington Legislature is capable of enacting regulations that serve the state's interest in preserving

[6] The district court applied the "undue burden" standard because "the constitutional rights at issue in this case are analogous to those in *Casey* and other decisions using an undue burden standard." *Compassion in Dying v. State of Washington*, 850 F. Supp. 1455, 1463-64 (W.D. Wash. 1994). But *Casey* does not reject the strict scrutiny standard of review in non-abortion cases. Because the instant case does not involve a challenge to a regulation of abortion rights, the traditional strict scrutiny test must be applied.

human life, while protecting the fundamental liberties of terminally ill, mentally competent adults. As Washington law now stands, the statute prevents all terminally ill, mentally competent adults from exercising their right to physician-hastened death. Because the legislature can draft laws that would protect plaintiffs' right to privacy, the existing legislation is not narrowly tailored.

The district court invalidated the statute on its face. According to plaintiffs' reply brief before the district court and their oral argument before us, they challenge the statute as it is applied to them as well as on its face. I would hold the statute invalid only as it is applied to terminally ill, mentally competent adults.

B. ***Equal Protection***

Washington law permits terminally ill persons to obtain medical assistance in withdrawing life-sustaining treatment. *See In re Grant*, 747 P.2d 445 (Wash. 1987); RCW 70.122 .010. Yet it prohibits other forms of physician-hastened death for terminally ill, mentally competent adults. Because Washington's laws abrogate the fundamental rights of one group, but not those of a similarly situated group, they must be subjected to strict scrutiny and upheld only if the classifications are suitably tailored to serve a compelling state interest. *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985).

The two groups of patients are similarly situated because they are both comprised of terminally ill, mentally competent adults. As observed by the district court, "[b]oth [groups of] patients may be terminally ill, suffering pain and loss of dignity and subjected to a more extended dying process without some medical intervention, be it removal of life support systems or the prescription of medication to be self-administered." 850 F. Supp. at 1467. There is but one difference: one group can hasten death

through withdrawal of life support; the other can do so only with affirmative medical assistance. Washington'sdisparate treatment drawn on this difference is not suitably tailored to serve a compelling state interest. Therefore, RCW 9A.36.060 violates plaintiffs' right to equal protection.

C. ***Conclusion***

The majority has denied plaintiffs the right to die with dignity. Terminally ill, mentally competent adults, like plaintiff patients, have a fundamental privacy right to choose physician-hastened death. RCW 9A.36.060, as applied to those persons, violates the privacy and equal protection guarantees of the Constitution.

I dissent.

APPENDIX E

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	No. C94-119R
Plaintiffs,	)	ORDER GRANTING IN PART AND DENYING IN PART PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT
v.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

I. INTRODUCTION

THIS COURT is asked to rule as a matter of first impression on the constitutionality of the State of Washington's criminal prohibition against physician-assisted suicide. Specifically, the plaintiffs assert that the

Fourteenth Amendment to the United States Constitution guarantees adults who are mentally competent, terminally ill, and acting under no undue influence the right to voluntarily hasten their death by taking a lethal dose of physician-prescribed drugs. Plaintiffs accordingly challenge the constitutionality of RCW 9A.36.060, which makes it a felony to knowingly aid another person in committing suicide. Plaintiffs challenge the statute only insofar as it bans physician-assisted suicide by mentally competent, terminally ill adults who knowingly and voluntarily choose to hasten their death.

The plaintiffs seek both a declaratory judgment striking down the statute as unconstitutional and injunctive relief barring defendants State of Washington and the Washington Attorney General from enforcing the statute. Both plaintiffs and defendants now move for summary judgment.[1]

II. BACKGROUND

A. DESCRIPTION OF PLAINTIFFS

The plaintiffs are a coalition of three terminally ill patients, five physicians who treat terminally ill patients, and Compassion in Dying, an organization which provides support, counseling and assistance to mentally competent, terminally ill adults considering suicide.

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[1] The court has also received a brief from amici curiae American Civil Liberties Union of Washington; Northwest Aids Foundation; Seattle Aids Support Group; Older Women's League; Gray Panthers of Seattle; Hemlock Society of Washington State; National Organization for Women, Seattle Chapter; National Lawyers Guild, Seattle Chapter; Local 6 of Service Employees International Union; and Temple De Hirsch Sinai. The court hereby GRANTS Northwest Women's Law Center's unopposed motion to participate as an additional amicus curiae.

1. The patients[2]

Jane Roe is a 69-year-old retired pediatrician who has suffered since 1988 from cancer which has now metastasized throughout her skeleton. Although she tried and benefitted temporarily from various treatments including chemotherapy and radiation, she is now in the terminal phase of her disease. In November of 1993, her doctor referred her to hospice care. Only patients with a life expectancy of less than six months are eligible for such care.

Jane Roe has been almost completely bedridden since June of 1993 and experiences constant pain, which becomes especially sharp and severe when she moves. The only medical treatment available to her at this time is medication, which cannot fully alleviate her pain. In addition, she suffers from swollen legs, bed sores, poor appetite, nausea and vomiting, impaired vision, incontinence of bowel, and general weakness.

Jane Roe is mentally competent and wishes to hasten her death by taking prescribed drugs with the help of plaintiff Compassion in Dying. In keeping with the requirements of that organization, she has made three requests for its members to provide her and her family with counseling, emotional support and any necessary ancillary assistance at the time she takes the drugs.

John Doe is a 44-year-old artist dying of AIDS. Since his diagnosis in 1991, he has experienced two bouts of pneumonia, chronic, severe skin and sinus infections, grand

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[2] To preserve their privacy, the patient plaintiffs have chosen to use pseudonyms. The court also notes that plaintiffs Jane Roe and John Doe have died since this case began. However, for purposes of examining the legal issue raised, the court will set forth their circumstances as they existed at the time the complaint was filed.

mal seizures and extreme fatigue. He has already lost 70% of his vision to cytomegalovirus retinitis, a degenerative disease which will result in blindness and rob him of his ability to paint. His doctor has indicated that he is in the terminal phase of his illness.

John Doe is especially cognizant of the suffering imposed by a lingering terminal illness because he was the primary caregiver for his long-term companion who died of AIDS in June of 1991. He also observed his grandfather's death from diabetes preceded by multiple amputations as well as loss of vision and hearing. Mr. Doe is mentally competent, understands there is no cure for AIDS, and wants his physician to prescribe drugs which he can use to hasten his death.

James Poe is a 69-year-old retired sales representative who suffers from emphysema, which causes him a constant sensation of suffocating. He is connected to an oxygen tank at all times, and takes morphine regularly to calm the panic reaction associated with his feeling of suffocation. Mr. Poe also suffers from heart failure related to his pulmonary disease which obstructs the flow of blood to his extremities and causes severe leg pain. There are no cures for his pulmonary and cardiac conditions, and he is in the terminal phase of his illness. Mr. Poe is mentally competent and wishes to commit suicide by taking physician-prescribed drugs.

2. The physicians

The five physician plaintiffs all regularly treat terminally ill patients. Dr. Harold Glucksberg is an assistant professor of medicine at the University of Washington School of Medicine and practices oncology, the treatment of cancer, at the Pacific Medical Center in Seattle. He has published dozens of articles in medical journals dealing with cancer.

In his declaration to the court, Dr. Glucksberg states:

> Cancer usually progresses steadily and slowly. The cancer patient is fully aware of his or her present suffering and anticipates certain future suffering. The terminal cancer patient faces a future that can be terrifying. Near the end, the cancer patient is usually bedridden, rapidly losing mental and physical functions, often in excruciating, unrelenting pain. Pain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental state because the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days either racked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

Declaration of Harold Glucksberg, M.D., pp. 3-5.

Dr. John P. Geyman was a professor and chair of the Department of Family Medicine at the University of Washington School of Medicine from 1976 through 1990. He is currently a professor emeritus at the University of Washington and has a private practice in family medicine. Dr. Geyman has published over seventy articles regarding family medicine in medical journals, has written several books in the field, was the founding editor of the Journal of Family Practice, and has served as editor since 1990 of the Journal of the American Board of Family Practice. Dr. Geyman states to the court that,

> in the presence of terminal illness, the shared goal of medical care at some point becomes comfort care rather than cure.

With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt. As a result, many experience prolonged deaths often involving pain, suffering and loss of dignity. In reaction to this problem, an increasing number of patients want more direct control over the type of care they receive in the last stage of their lives. A subset of dying patients desire to shorten their dying process and thereby avoid a lingering death and associated pain, suffering and loss of dignity.

Terminally ill persons who seek to hasten death by consuming drugs need medical counseling. . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task.

> It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. These efforts are often unsuccessful and can cause the patient and family increased anxiety, pain and suffering. Very often, patients who survive a failed suicide attempt find themselves in worse shape than before the attempt.

Declaration of John P. Geyman, M.D., pp. 3-5.

Dr. Thomas A. Preston is currently chief of the cardiology unit at Pacific Medical Center in Seattle. He has published numerous articles and books in the field of cardiology, and has received numerous honors for medical teaching and writing. Dr. Preston regularly treats patients dying from cardiopulmonary diseases, a process which can last several months. Dr. Abigail Halperin practices family

medicine and occasionally treats patients with terminal illnesses including cancer and AIDS. Dr. Peter Shalit practices general internal medicine; a substantial number of his patients suffer from HIV infection and AIDS. Both Dr. Halperin and Dr. Shalit are also clinical instructors at the University of Washington School of Medicine.

The five physician plaintiffs all state that they have received requests from terminally ill, mentally competent patients in the final stage of their diseases who wished assistance in hastening death. Although their professional judgments have at times dictated that they should assist such patients, they have all been deterred from doing so by the existence of the Washington statute challenged in this case.[3]

3. Compassion in Dying

Compassion in Dying is a Washington nonprofit organization which provides information, counseling and assistance free of charge to mentally competent, terminally ill adult patients considering suicide and to the families of such patients.

Compassion in Dying operates under a written protocol and has strict eligibility requirements for the individuals to whom it provides services. Eligible patients must be considered terminally ill in the judgment of the primary care physician and must be capable of understanding their own decisions. Evaluation by a mental health professional

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[3] Although the statute operates to deter physicians from prescribing drugs for the purpose of hastening death, it does not necessarily deter the patient who requested the drugs from committing suicide by other means. Both Dr. Halperin and Dr. Glucksberg recount personal experiences with terminally ill patients who killed themselves by violent means after being refused a drug prescription. Declaration of Abigail Halperin, M.D., pp. 4-5; Declaration of Harold Glucksberg, M.D., pp. 5-6.

may be obtained to insure that the patient's request is not motivated by depression, emotional distress or mental illness. A request for assisted suicide must not be the result of inadequate comfort care, nor can it be motivated by a lack of adequate health insurance or other economic concerns. The request must come from the patient personally, in writing or on videotape, and must be repeated three times, with an interval of at least 48 hours between the second and third requests. Requests may not be made through advance directives or by a health care surrogate, attorney-in-fact or any other person.

According to its guidelines, Compassion in Dying will not assist anyone to commit suicide who expresses any ambivalence or uncertainty. If the patient has immediate family members or other close personal friends, their approval must be obtained. If any members of the immediate family express disapproval, Compassion in Dying will not provide assistance with suicide. As an additional safeguard, Compassion in Dying requires the patient to provide medical records. A consulting physician must review them to verify the patient's terminal prognosis and decision-making capability as well as to rule out inadequate pain management as the reason for requesting assisted suicide.

Defendants do not contest the factual declarations by the various plaintiffs, except to deny that the physicians' personal statements of their professional standards are in accord with either the ethical standards or the licensing laws applicable to their profession.

B. WASHINGTON'S STATUTE PROHIBITING ASSISTED SUICIDES

Washington has no law prohibiting suicide or attempted suicide. However, Washington bans aiding or causing the suicide of another:

> A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.

RCW 9A.36.060(1). Promoting a suicide attempt is a class C felony punishable by imprisonment for a maximum of five years and a fine of up to ten thousand dollars. RCW 9A.36.060(2) and 9A.20.020(1)(c).

C. DESCRIPTION OF PLAINTIFFS' CLAIMS

All of the plaintiffs assert a facial challenge to the constitutionality of RCW 9A.36.060 prohibiting assisted suicide. However, plaintiffs' specific claims vary because of their differing circumstances. Jane Roe, John Doe and James Poe allege that they, as mentally competent, terminally ill adults with no chance of recovery, have a constitutionally protected liberty interest under the Fourteenth Amendment which gives them the right to commit physician-assisted suicide without undue governmental interference. Thus, they challenge the constitutionality of the statute insofar as it bars physicians from aiding informed, mentally competent, terminally ill adults to commit suicide. They also attack the statute on equal protection grounds.

The plaintiff physicians assert claims on behalf of their mentally competent, terminally ill adult patients who seek to commit suicide with drugs prescribed for that purpose. The physicians also allege that the Fourteenth Amendment protects their right to practice medicine consistent with their best professional judgment, including the right to assist competent, terminally ill adult patients to hasten death by prescribing suitable medication for self-administration by the patient.

Compassion in Dying's alleged organizational purpose is to assist competent, terminally ill adults who wish to commit suicide by self-administering prescription

medications. Compassion in Dying contends that such persons have the right to request assistance from its staff members, including counseling and delivering or mixing the drugs that are to be used. Under current Washington law prohibiting any form of assisted suicide, Compassion in Dying fears that it may be criminally prosecuted for its activities in assisting dying persons as they exercise their alleged constitutional right to hasten their own deaths.

III. LEGAL ANALYSIS

A. EXISTENCE OF PROTECTED LIBERTY INTEREST

The Fourteenth Amendment to the United States Constitution declares that the state may not "deprive any person of life, liberty, or property, without due process of law." Plaintiffs assert the existence of a liberty interest protected by the Fourteenth Amendment which extends to a personal choice by a mentally competent, terminally ill adult to commit physician-assisted suicide. They contend that individuals in those circumstances have a constitutionally protected right to be free from undue governmental intrusion on their decision to hasten death and avoid prolonged suffering.

1. Liberty Interest under *Planned Parenthood v. Casey*

The United States Supreme Court has established through a long line of cases that personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education are constitutionally protected. Planned Parenthood v. Casey, ___ U.S. ___, ___, 112 S. Ct. 2791, 2807 (1992). As explained in Casey,

> [t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy,

> are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id.

The opinion in Casey involved a woman's right to choose abortion, and thus did not address the question of what liberty interest may inhere in a terminally ill person's choice to commit suicide. However, this court finds the reasoning in Casey highly instructive and almost prescriptive on the latter issue. Like the abortion decision, the decision of a terminally ill person to end his or her life "involv[es] the most intimate and personal choices a person may make in a lifetime" and constitutes a "choice[ ] central to personal dignity and autonomy."

The court in Casey spoke of the suffering of the pregnant woman, which "is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture." Id. Casey further acknowledged the deep, heart-felt differences of opinion about the morality of abortion, but recognized that the court's duty is not to impose a particular moral standard:

> Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter . . . .

Id. at 2806.

This court is well aware of the similarly divisive controversy about the appropriateness of suicide by the terminally ill. But the underlying constitutional issue is whether the State of Washington can resolve the profound spiritual and moral questions surrounding the end of life in so conclusive a fashion as to deny categorically any option for a terminally ill, mentally competent person to commit physician-assisted suicide. This court concludes that the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman. Thus, consonant with the reasoning in Casey, such an intimate personal decision falls within the realm of the liberties constitutionally protected under the Fourteenth Amendment.

Defendants point out that the Washington State legislature might, in the future, decide to amend the statute prohibiting all assisted suicide so as to make an exception for physician-assisted suicide. Defendants strongly urge the court to leave this decision to the State legislature, which will in turn reflect the will of the people living in Washington. But where a constitutional right is involved, this court simply may not abdicate its responsibility to face the issue, no matter how difficult or divisive. Under those circumstances, this court is legally bound to recognize the right and determine how it affects the outcome of the case before it.

Defendants also argue that the Casey analysis is inapposite because there are significant differences between reproductive rights and assisted suicide. First, defendants contend that the level of personal autonomy is greater in the area of reproductive rights because of the greater level of control that humans have historically been able to

exercise over the beginning of life, as opposed to the end of life, which usually results from forces outside individual control. Assuming that defendants' observation is correct, this hardly amounts to a distinction that warrants a different constitutional result.

Second, defendants contend that the competing interests differ in cases involving reproductive rights and assisted suicide. In the former, the ongoing life interest of the woman is pitted against the potential life interest of the fetus. In the latter, the interests of the person who wishes to take his or her own life must be weighed against the interests of similarly situated persons who might be subject to undue influence if assisted suicide were allowed.

The court agrees that the competing interests differ, but concludes that if any comparison can be made between the two types of decisions, both of which are emotionally complicated and fraught with social implications, the abortion situation raises more difficult questions about competing interests. In reproductive rights cases, there is not only the interest of the pregnant woman seeking an abortion, but also the potential life interest which cannot speak for itself. By contrast, in the case of assisted suicide involving a competent person, only one life is involved and that individual can voice his or her wishes.

Third, defendants contend that any system allowing assisted suicide would create the potential for abuse and undue influence, whereas recognizing a right to abortion does not raise the specter of undue influence from others with regard to making a decision to abort. This argument is unpersuasive. One can readily imagine many situations in which a pregnant woman or girl could be subjected to intense pressure from others to get an abortion.

Finally, defendants maintain that reproductive rights analysis differs from assisted suicide issues because of the

difference in the level of medical knowledge between the two situations. According to defendants, much more is known about the medical possibilities at the beginning of life than at the end. Even assuming the truth of defendants' argument, it is irrelevant. Casey and its progenitors did not base the right to choose abortion on the level of medical knowledge about human reproduction, but on the idea that there is a constitutionally protected "realm of personal liberty which the government may not enter." Id. at 2805. The question for this court is whether the choice to commit physician-assisted suicide falls within that realm. This determination is not dependent on advancements in medical science.

2. Liberty interest under *Cruzan v. Director, Missouri Dept. of Health*

In addition to Casey, the court also finds Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990), instructive. In Cruzan, the Supreme Court considered whether a competent person has a constitutionally protected liberty interest in refusing unwanted, life-sustaining medical treatment including artificially delivered food and water essential to life. In his majority opinion, Justice Rehnquist acknowledged that this principle "may be inferred from our prior decisions," id. at 278, and that "the logic of the cases . . . would embrace such a liberty interest." Id. at 279. He then assumed for purposes of the case before the Court "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." Id.[4]

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[4] The court notes that Justice O'Connor's concurring opinion concluded that there is a constitutionally protected liberty interest at stake:

> Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

Cruzan, 110 S. Ct. at 289.

This court is confident that, squarely faced with the issue, the Supreme Court would reaffirm Justice Rehnquist's tentative conclusion in Cruzan that a competent person has a protected liberty interest in refusing unwanted medical treatment, even when that treatment is life-sustaining and refusal or withdrawal of the treatment would mean certain death. The question then becomes whether a constitutional distinction can be drawn between refusal or withdrawal of medical treatment which results in death, and the situation in this case involving competent, terminally ill individuals who wish to hasten death by self-administering drugs prescribed by a physician. In other words, is there a difference for purposes of finding a Fourteenth Amendment liberty interest between refusal of unwanted treatment which will result in death and committing physician-assisted suicide in the final stage of life?

The liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one's individual conscience about those matters which are essential to personal autonomy and basic human dignity. There is no more profoundly personal decision, nor one which is closer to the heart of personal liberty, than the choice which a terminally ill person makes to end his or her suffering and hasten an inevitable death. From a constitutional perspective, the court does not believe that a distinction can be drawn between refusing life-sustaining medical treatment and physician-assisted suicide by an uncoerced, mentally competent, terminally ill adult.

Based on the reasoning set forth in Casey and Cruzan, the court concludes that a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted suicide.[5]

B. STANDARD OF REVIEW

Regarding the applicable standard of review, the Supreme Court held in Casey that, in order to demonstrate the unconstitutionality of a state statute, plaintiffs had to show that it would "operate as a substantial obstacle" to the exercise of a constitutional right and would, therefore,

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[5] The court is aware of no other federal cases directly addressing the issue raised in this case. However, two state cases have been brought to the court's attention. In People v. Kevorkian, No. 93-11482 (Wayne Cty. Cir. Ct., Mich. 1993) defendant physician was prosecuted for violating a Michigan statute making it a felony to provide the physical means, or to participate in a physical act, by which another person commits suicide. On December 13, 1993, the Circuit Court for Wayne County, Michigan found that the Michigan statute prohibiting assisted suicide was unconstitutional insofar as it infringed on a person's Fourteenth Amendment liberty interest in committing "rational suicide," which the court defined as existing:

> when a person's quality of life is significantly impaired by a medical condition and the medical condition is extremely unlikely to improve, and that person's decision to commit suicide is a reasonable response to the condition causing the quality of life to be significantly impaired, and the decision to end one's life is freely made without undue influence . . . .

Id. at 34-35. The case is now pending before the Michigan Court of Appeals.

Another case cited by the defendants is Donaldson v. Lundgren, 2 Cal.App. 4th 1614, 4 Cal.Rptr.2d 59 (2d Dist. 1992). Plaintiff in that case suffered from an incurable brain disease and wished to commit suicide with the assistance of a third person so that his body could be cryogenically preserved and brought back to life in the future when a cure for his disease had been found. The court refused to find that plaintiff had a constitutional right to commit assisted suicide under the circumstances presented. Given the very unusual facts in Donaldson, this court does not find the case helpful.

constitute an "undue burden." 112 S. Ct. at 2830. Defendants in this case respond that since plaintiffs are bringing a facial challenge to the validity of RCW 9A.36.060, the applicable standard is set forth in United States v. Salerno, 481 U.S. 739, 745 (1987), which requires plaintiffs to show that "no set of circumstances exists under which the [law] would be valid." The court concludes that the Casey "undue burden" standard, set forth by the Supreme Court five years after Salerno, controls in this case.

In Casey, the joint opinion by Justice O'Connor, Justice Kennedy and Justice Souter held that the appropriate test for a facial challenge to the constitutionality of abortion regulations was whether the "state regulation imposes an undue burden on a woman's ability to make [a] decision" concerning whether or not to procure an abortion. Casey, 112 S. Ct. at 2819. In his partial concurrence, Justice Stevens enunciated the following two-part test which must be met for the regulation to survive constitutional scrutiny: "A burden may be 'undue' either because the burden is too severe or because it lacks a legitimate, rational justification." Id. at 2843 (footnote omitted). Justice Blackmun, according to his partial concurrence, would have required that "a State's abortion restrictions be subjected to the strictest of judicial scrutiny." Id. at 2845-46. Thus, five of the Justices in Casey found the "undue burden" standard to be appropriate or would have applied an even higher level of scrutiny to the abortion restrictions at issue in that case.

The Supreme Court in Casey stated that "[i]t is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decision about family . . . as well as bodily integrity," id. at 2806 (citations omitted), and that "the undue burden standard is the appropriate means of reconciling the State's interest

with the woman's constitutionally protected liberty." Id. at 2820. As in Casey, this case concerns matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, . . . central to the liberty protected by the Fourteenth Amendment." Id. at 2807. As in Casey, the liberty interest at issue in this case is similarly "a right 'to be free from unwarranted governmental intrusion into matters . . . fundamentally affecting a person.'" Id. at 2819 (quoting Eisenstadt v. Baird, 405 U.S. 438, 453 (1972)). In addition, the Court in Casey referred to the undue burden standard as "a standard of general application to which we intend to adhere." 112 S. Ct. at 2820.

Since the Supreme Court's decision in Casey, three Circuit Courts of Appeals have addressed the possible contradiction between Salerno and Casey concerning the applicable standard for a facial challenge to the constitutionality of a statute. In addition, Justices O'Connor and Souter have had two occasions to discuss the applicability of the Casey undue burden standard.

In Barnes v. Moore, 970 F.2d 12 (5th Cir.), cert. denied, ___ U.S. ____, 113 S. Ct. 656 (1992), the Fifth Circuit followed the Salerno standard, although it acknowledged that this might not be consistent with the standard applied in the joint opinion in Casey. Indeed, the Barnes court cited Justice Rehnquist's dissent in Casey in which he disputes the appropriateness of the undue burden standard set out by the joint opinion. Barnes, 970 F.2d at 14.

In contrast, the Third Circuit in Casey v. Planned Parenthood, 14 F.3d 848 (3rd Cir.1994) ("Casey II"), stated that the Supreme Court in Casey had "set a new standard for facial challenges to pre-viability abortion laws." Id. at 863, n.21. The Third Circuit court

concluded that "Casey requires only that a plaintiff show an abortion regulation would be an undue burden 'in a large fraction of the cases.'" Id.

In denying the application for a stay of the Third Circuit's mandate in Casey II, Justice Souter noted that the Third Circuit "Court of Appeals's construction of the opinion and mandate . . . is the correct one." Planned Parenthood v. Casey, ___ U.S. ____, 114 S. Ct. 909, 911 (1994). Justice Souter stated that he

> join[ed] the applicants and the courts below in treating the joint opinion in Casey, . . . to be controlling, as the statement of the Members of the Court who concurred in the judgment on the narrowest grounds.

Id. at 910, n.2 (citations omitted).

In Fargo Women's Health Org. v. Schafer, ___ U.S. ____, 113 S. Ct. 1668 (1993), an application for a stay and injunction was filed with the Supreme Court while the case was pending on appeal before the Eighth Circuit. In denying the application for a stay, Justice O'Connor, joined by Justice Souter, concurred but wrote separately "to point out that [the] denial of relief should not be viewed as signaling agreement with the lower courts' reasoning." Id. at 1669. Justice O'Connor stated:

> In my view, the approach taken by the lower courts is inconsistent with Casey. In striking down Pennsylvania's spousal-notice provision, we did not require petitioners to show that the provision would be invalid in all circumstances. Rather, we made clear that a law restricting abortions constitutes an undue burden, and hence is invalid, if, "in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion. . . .

> While I express no view as to whether the particular provisions at issue in this case constitute an undue burden, I believe the lower courts should have undertaken the same analysis.

Id. at 1669 (citation omitted) (emphasis in original).[6]

Because the constitutional rights at issue in this case are analogous to those in Casey and other decisions using an undue burden standard[7] for facial constitutional challenges, this court is convinced that the undue burden standard set out in Casey is the appropriate standard for determining the constitutional validity of RCW 9A.36.060.[8]

C. UNDUE BURDEN ANALYSIS

Pursuant to the standard set forth in Casey, the court will first examine the alleged State interests in maintaining

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[6] Despite the language of Justices O'Connor and Souter in the denial of the applications for stays in Fargo Women's Health Org. v. Schafer and in Casey II, the Eighth Circuit Court of Appeals, in its decision on the merits in the Fargo case, analyzed the case before it under both the Salerno standard and the Casey standard. The Eighth Circuit concluded that, on the facts presented in that case, the result would be the same under either standard. Fargo Women's Health Org. v. Schafer, No. 93-1579, 1994 U.S. App. LEXIS 2141 (8th Cir. 1994).

[7] See e.g., Maher v. Roe, 432 U.S. 464, 473-474 (1977) ("[The constitutional right declared in Roe v. Wade] protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy."); Doe v. Bolton, 410 U.S. 179, 198 (1973) ("[T]he interposition of the hospital abortion committee is unduly restrictive of the patient's rights."); Bellotti v. Baird, 428 U.S. 132, 147 (1976) (state may not "impose undue burdens upon a minor capable of giving an informed consent").

[8] This court is persuaded that the Supreme Court analysis in Casey applies to the circumstances at issue in this case. However, this court need not address whether the Casey undue burden standard is applicable outside the realm of personal liberties of this type.

a total prohibition on all assisted suicides, and then will determine whether the challenged statute in this case places a substantial obstacle in the path of individuals seeking to exercise a constitutionally protected right.

1. State's Interests

Defendants cite two primary interests furthered by the challenged statute: preventing suicide and protecting those at risk of suicide from undue influence from others who would aid them in completing the act.

a. Preventing suicide

In support of the first interest, prevention of suicide,[9] defendants point to statistics concerning the rate of suicide in Washington among various age groups, particularly the young. Obviously, the State has a strong, legitimate

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[9] Notably, the statute at issue does not bar suicide, nor does any other Washington statute. See Washington Laws of 1975, 1st Ex.Sess. ch. 260, § 9A.36.060, which amended the Washington statute governing suicide by repealing the prohibition against attempting suicide, but retained the prohibition against assisting another in committing suicide. Needless to say, this change in the law did not suggest approval of the act of suicide, but rather a determination that the person compelled to attempt it should not be punished if the attempt proved unsuccessful. See Legislative Council's Judiciary Committee, Report on the Revised Washington Criminal Code 153 (Dec. 3, 1970); and Report of the Task Force of the Washington State Bar Association Concerning the Proposed Criminal Code (Sept. 6, 1974). Thus, a terminally ill patient who commits suicide with a doctor's help has not performed an illegal act; only the doctor's actions are subject to legal censure.

As for the law in other jurisdictions, there is no criminal prohibition against attempting suicide in any state. According to defendants, twenty-eight other states besides Washington currently have statutes barring assisted suicide. Defs.' Memo. in Opp. to Pls. Mot. for Summ. J. and in Supp. of Summ. Judg. for Defs., pp. 6-7 n.15. Thus, twenty-one states have no legislation specifically criminalizing assisted suicide.

interest in deterring suicide by young people and others with a significant natural life span ahead of them.

But this case is not about people for whom suicide would abruptly cut life short. Plaintiffs in this case are people suffering through the final stage of life with no hope of recovery. As to them, preventing suicide simply means prolonging a dying person's suffering, an aim in which the State can have no interest. In other words, the State's legitimate interest in preventing suicide is not abrogated by allowing mentally competent, terminally ill patients to freely and voluntarily commit physician-assisted suicide.

The State's interest in preventing suicide by prohibiting any manner of assisted suicide in actuality arises out of its apprehension of the "slippery slope" problem. The State is concerned that allowing any exception to a total ban will encourage the gradual development of a more permissive attitude toward suicide. That attitude, the State fears, will in turn erode the societal constraints now hindering people from committing suicide themselves or countenancing the thought as an appropriate course of action for others, and will result in more suicides by those temporarily depressed, distraught or mentally disturbed.

The court recognizes the tragedy involved when, for example, suicide ends a young life that, with timely and appropriate counseling, could have continued. But despite the general validity of the State's concern, the slippery slope argument cannot prevail in this instance. It may be difficult to define the kinds of assistance which are necessary and should be permitted in order to honor terminally ill patients' protected liberty interest in hastening their death. However, that is not a sufficient excuse for precluding entirely the exercise of a constitutional right. The court has no doubt that the legislature can devise regulations which will define the appropriate boundaries of

physician- assisted suicide for terminally ill individuals, and at the same time give due recognition to the important public policy concerns regarding the prevention of suicide.

b. Preventing Undue Influence and Abuse

The State's second stated interest, protecting people from committing suicide due to undue influence or duress, is also unquestionably a legitimate consideration. But it is undisputed that plaintiffs in this case are mentally competent individuals who have reached a decision to commit physician-assisted suicide free of any undue influence. Thus, the plaintiffs and others who make knowing and voluntary choices to commit physician-assisted suicide by definition fall outside the realm of the State's concern.

Moreover, Washington State law permits an individual to refuse or require the withdrawal of life-sustaining treatment. See the Natural Death Act, RCW 70.122 et seq., which outlines the legal requirements for executing a written directive refusing all life-sustaining medical treatment in the event of terminal illness or permanent unconscious condition. See also In re Guardianship of Grant, 109 Wash.2d 545, 747 P.2d 445 (1987); and In re Guardianship of Hamlin, 102 Wash.2d 810, 689 P.2d 1372 (1984), in which the Washington Supreme Court recognized the right of a competent, terminally ill adult to refuse life-sustaining medical treatment. Finally, Washington law also recognizes that decisions about life-sustaining medical treatment may be exercised by an authorized representative holding a durable power of attorney for health care. RCW 70.122.010.

The potential risk of abuse and undue influence is often just as great and may be greater in certain cases for a patient who requests to be disconnected from a life support system. The risk of abuse is especially present if

the patient is incompetent and a surrogate is making the decision.[10]

2. Existence of Undue Burden

As discussed above, the court must determine pursuant to the Casey undue burden standard whether the challenged statute "has the purpose or effect of placing a substantial obstacle in the path" of a person seeking to commit physician-assisted suicide. 112 S. Ct. at 2820. According to the Casey standard, a statute with this purpose is invalid because the means chosen by the state to further its interest in preventing undue influence "must be calculated to inform the person's free choice, not hinder it." Id. Moreover, "a statute which, while furthering . . . [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends." Id.

In this case, the challenged statute not only places a substantial obstacle in the path of a terminally ill, mentally competent person wishing to commit physician-assisted suicide, but entirely prohibits it. There is no question that such a total ban places an undue burden on the exercise of a constitutionally protected liberty interest.

The court finds that neither of the two alleged State interests, preventing suicide and protecting people against undue influence from others, would be impeded by allowing physician-assisted suicide for mentally competent, terminally ill adult patients. By reaching this conclusion,

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[10] If the State's concern is determining whether a decision is coerced, the court notes that the law regularly deals with the question of evaluating the voluntariness of decisions. Undoubtedly the legislature can devise regulations which would set up a mechanism for ensuring that people who decide to commit physician-assisted suicide are not acting pursuant to abuse, coercion or undue influence from third parties.

the court does not mean to dismiss the importance or legitimacy of the State's interests in deterring suicide or to suggest that the State has no ability to regulate assisted suicide. Clearly, the State can regulate in this area as long as the regulation does not constitute an undue burden on the exercise of a constitutional right and is reasonably related to a legitimate state interest. Casey, 112 S. Ct. at 2821.

In this case specifically, the court recognizes the legitimacy of the State's interest in preventing undue influence by third parties who may seek to coerce or manipulate a person into committing suicide. But this concern can be answered by devising safeguards and imposing restrictions on physician-assisted suicide to ensure the knowing and voluntary nature of the decision. It is well within the legislative prerogative to enact regulations and restrictions which will ensure that undue influence from third parties plays no part in the choice of physician-assisted suicide.

D. EQUAL PROTECTION

Plaintiffs also assert that RCW 9A.36.060 denies them equal protection of the law as guaranteed by the United States Constitution. The Equal Protection Clause of the Fourteenth Amendment "is essentially a direction that all persons similarly situated should be treated alike." City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432, 439 (1984) (citing Plyler v. Doe, 457 U.S. 202, 216 (1982)). When state laws infringe on constitutionally protected personal rights of some people, but not others similarly situated, those laws are subjected to strict scrutiny and will be sustained only if the classifications are suitably tailored to serve a compelling state interest. Cleburne, 473 U.S. at 440; see also Shapiro v. Thompson, 394 U.S. 618, (1969) (one-year residency requirement for welfare benefits held

to violate equal protection); Skinner v. Oklahoma, 316 U.S. 535 (1942) (statute providing for sterilization of "habitual criminals" for "felonies involving moral turpitude" which contained an exception for embezzlers violated equal protection as applied to defendant); Kramer v. Union Free School Dist., 395 U.S. 621 (1969) (striking down school district election voter qualifications as violative of equal protection). Government action burdening the fundamental rights of one group more than that of another group subjects the classification to strict scrutiny. Loving v. Virginia, 388 U.S. 1 (1967) (anti-miscegenation law held to violate equal protection guarantee); Eisenstadt v. Baird, 405 U.S. 438 (1972) (law prohibiting sale of contraceptives to single persons, but not to married persons, was invalid as underinclusive, invidious distinction).

Plaintiffs in this case contend that Washington State law unconstitutionally distinguishes between two similarly situated groups of mentally competent, terminally ill adults. Under current state law, those terminally ill persons whose condition involves the use of life-sustaining equipment may lawfully obtain medical assistance in terminating such treatment, including food and water, and thereby hasten death, while those who also suffer from terminal illnesses, but whose treatment does not involve the use of life support systems, are denied the option of hastening death with medical assistance.[11]

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[11] The parties agree that the Washington State Supreme Court has recognized the right of competent, terminally ill adults to refuse life-sustaining treatment. See Grant, 109 Wash.2d 545, 747 P.2d 445 (1987); Hamlin, 102 Wash.2d 810, 689 P.2d 1372 (1984); In re Guardianship of Bowman, 94 Wash.2d 407, 617 P.2d 731 (1980). See also In re Guardianship of Colyer, 99 Wash.2d 114, 119-21, 660 P.2d 738 (1983) (guardian may assert an incompetent individual's personal right to refuse life-sustaining treatment).

Defendants argue that the distinction between the two groups of competent, terminally ill adults does not violate the Fourteenth Amendment's guarantee of equal protection because death resulting from the removal of life support systems is "natural" and death resulting from medical assistance other than removal of life support is "artificial." Defs.' Mem. in Opp. at 21-22. Defendants assert that the governmental interest in preventing suicide is "not implicated in an individual's refusal of life sustaining treatment," id. at 21, but is implicated in the context of physician-assisted suicide, and that the compelling state interest requirement is therefore satisfied. The court finds the two groups of mentally competent, terminally ill adults at issue here to be similarly situated. While the court recognizes that the governmental interest in preventing suicide is a compelling state interest, Washington caselaw and the Washington Natural Death Act have already carved out an exception for terminally ill patients, and others,[12] wishing to terminate life support. Thus, the State has already recognized that its interest in preventing suicide does not require an absolute ban.

This court is not persuaded that the distinction between "natural" and "artificial" death justifies disparate treatment

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In addition, the Washington Natural Death Act, RCW 70.122 et seq., states that:

> adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn, in instances of a terminal condition or permanent unconscious condition, . . .

RCW 70.122.010.

[12] RCW 70.122 et seq., the Natural Death Act, is not limited to termination of life support for patients who are terminally ill, but also includes patients who are in a "permanent unconscious state." RCW 70.122.010.

of these similarly situated groups. The distinction between the terminally ill patient who requests that her physician remove the life support systems necessary to maintain her life, and the terminally ill patient whose condition does not require life support systems but who seeks physician-administered aid to end her life, is not a narrowly-drawn classification tailored to serve a compelling state interest. Both patients may be terminally ill, suffering pain and loss of dignity and subjected to a more extended dying process without some medical intervention, be it removal of life support systems or the prescription of medication to be self-administered.

Washington law, by creating an exception for those patients on life support, yet not permitting competent, terminally ill adult patients such as plaintiffs the equivalent option of exercising their rights to hasten their deaths with medical assistance, creates a situation in which the fundamental rights of one group are burdened while those of a similarly situated group are not. Therefore, this court finds that RCW 9A.36.060 violates the equal protection guarantee of the Fourteenth Amendment.

E. CLAIMS BY PLAINTIFF PHYSICIANS AND COMPASSION IN DYING

The five physician plaintiffs and Compassion in Dying have all asserted claims on their own behalf in the complaint. However, none of these claims is discussed in the briefs now before the court on the parties' summary judgment motions. Since plaintiffs have failed to brief these issues, the court will not address them.

IV. CONCLUSION

The court declares RCW 9A.36.060 unconstitutional because it places an undue burden on the exercise of a protected Fourteenth Amendment liberty interest by terminally ill, mentally competent adults acting knowingly

and voluntarily, without undue influence from third parties, who wish to commit physician-assisted suicide. The court further declares RCW 9A.36.060 unconstitutional because it violates the right to equal protection under the Fourteenth Amendment by prohibiting physician-assisted suicide while permitting the refusal or withdrawal of life support systems for terminally ill individuals.

The motion for summary judgment filed by plaintiffs Jane Roe, John Doe and James Doe is accordingly GRANTED, and defendants' cross-motion for summary judgment as to those claims is DENIED. The physician plaintiffs' motion for summary judgment is GRANTED insofar as the physicians purport to raise claims on behalf of their terminally ill patients. The physician plaintiffs' motion for summary judgment is DENIED as to their own claims on the grounds that the basis for those claims has not been adequately addressed. For the same reason, plaintiff Compassion in Dying's claim on its own behalf is DENIED at this time.

As for the injunctive relief requested by plaintiffs, the court declines to enter an injunction barring defendants from enforcing RCW 9A.36.060.[13]

DATED at Seattle, Washington this 3rd day of May, 1994.

/s/
BARBARA J. ROTHSTEIN
CHIEF UNITED STATES DISTRICT JUDGE

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[13] Defendants also point out that the county prosecuting attorneys, and not defendant Attorney General, have primary responsibility for prosecuting violations of the criminal laws. Therefore, enjoining the Attorney General would be a largely useless exercise. Defs.' Mem. in Opp., pp. 23-24.

APPENDIX F

SUPREME COURT OF THE UNITED STATES
OFFICE OF THE CLERK
WASHINGTON, DC 20543-0001

WILLIAM K. SUTER
CLERK OF THE COURT

AREA CODE 202
479-3011

May 14, 1996

Mr. William L. Williams
Highways-Licenses Building
P.O. Box 40113
Olympia, WA 98504-0113

Re: Washington and Christine O. Gregoire, Attorney General of Washington
v. Harold Glucksberg, et al.
Application No. A-919

Dear Mr. Williams:

The application for an extension of time within which to file a petition for a writ of certiorari in the above-entitled case has been presented to Justice O'Connor, who on May 14, 1996, extended the time to and including July 4, 1996.

This letter has been sent to those designated on the attached notification list.

Sincerely,

WILLIAM K. SUTER, Clerk

By /s/

Jeffrey D. Atkins
Assistant Clerk

NOTIFICATION LIST

Mr. William L. Williams
Highways-Licenses Building
P.O. Box 40113
Olympia, WA 98504-0113

Ms. Kathryn Tucker
1201 Third Avenue
40th Floor
Seattle, WA 98101

Cathy A. Catterson
United States Court of Appeals for
the Ninth Circuit
P.O. Box 193939
San Francisco, CA 94119-3939

APPENDIX G

LEGISLATIVE HISTORY OF REVISED CODE OF WASHINGTON 9A.36.060

LAWS OF WASHINGTON TERRITORY, 1854

AN ACT RELATIVE TO
CRIMES AND PUNISHMENTS,
AND PROCEEDINGS IN CRIMINAL CASES

CHAPTER II

Sec. 17. Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter.

LAWS OF WASHINGTON TERRITORY, 1869

AN ACT RELATIVE TO
CRIMES AND PUNISHMENTS
AND PROCEEDINGS IN CRIMINAL CASES

CHAPTER II

Sec. 17. Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter.

LAWS OF WASHINGTON TERRITORY, 1873

AN ACT RELATIVE TO
CRIMES AND PUNISHMENTS
AND PROCEEDINGS IN CRIMINAL CASES

CHAPTER II

Sec. 19. Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter.

WASHINGTON CODE OF 1881

CHAPTER LXVIII

OFFENSES AGAINST THE LIVES OF
PERSONS AND INDIVIDUALS

Sec. 794. Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter.

WASHINGTON LAWS OF 1909

CHAPTER 249

Sec. 135. *Aiding Suicide.*

Every person who, in any manner, shall wilfully advise, encourage, abet or assist another in taking his own life shall be guilty of manslaughter.

Sec. 136. *Abetting Attempt at Suicide.*

Every person who, in any manner, shall wilfully advise, encourage, abet or assist another in attempting to take the latter's life shall be punished by imprisonment in the state penitentiary for not more than ten years.

WASHINGTON LAWS OF 1975,
FIRST EXTRAORDINARY SESSION

CHAPTER 260

NEW SECTION. Sec. 9A.36.060 PROMOTING A SUICIDE ATTEMPT. (1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.

(2) Promoting a suicide attempt is a Class C felony.

APPENDIX H

INITIATIVE MEASURE 119

AN ACT Relating to the natural death act; and amending RCW 70.122.010, 70.122.020, 70.122.030, 70.122.040, 70.122.050, 70.122.060, 70.122.070, 70.122.080, 70.122.090, 70.122.100, and 70.122.900.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF WASHINGTON:

Sec. 1. Section 2, chapter 112, Laws of 1979 and RCW 70.122.010 are each amended to read as follows:

The ((~~legislature~~)) people find((s)) that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have all life-sustaining procedures withheld or withdrawn in instances of a terminal condition, and including the right to death with dignity through voluntary aid-in-dying if suffering from a terminal condition.

The ((~~legislature~~)) people further find((s)) that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The ((~~legislature~~)) people further find((s)) that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The ((~~legislature~~)) people further find((s)) that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient

has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

The people further find that existing law does not allow willing physicians to render aid-in-dying to qualified patients who request it.

In recognition of the dignity and privacy which patients have a right to expect, the ((~~legislature~~)) people hereby declare((s)) that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition, and/or to request and receive aid-in-dying under the provisions of this chapter.

Sec. 2. Section 3, chapter 112, Laws of 1979 and RCW 70.122.020 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(2) "Directive" means a written document voluntarily executed by the declarer in accordance with the requirements of RCW 70.122.030.

(3) "Health facility" means a hospital as defined in RCW ((~~70.38.020(7) or~~)) 70.41.020(2), a nursing home as defined in RCW ((~~70.38.020(8)~~)) 18.51.010, or a home health agency or hospice agency as defined in RCW 70.126.010.

(4) "Life-sustaining procedure" means any medical or surgical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death ((~~and where, in the judgment of the~~

~~attending physician, death is imminent whether or not such procedures are utilized~~)). "Life-sustaining procedure" includes, but is not limited to, cardiac resuscitation, respiratory support, and artificially administered nutrition and hydration, but shall not include the administration of medication to relieve pain or the performance of any medical procedure deemed necessary to alleviate pain.

(5) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(6) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians one of whom shall be the attending physician, who have personally examined the patient.

(7) "Terminal condition" means an incurable ((~~condition caused by injury, disease, or illness, which, regardless of the application of life sustaining procedures, would within reasonable medical judgment, produce death, and where the application of life sustaining procedures serve only to postpone the moment of death of the patient.~~)) or irreversible condition which, in the written opinion of two physicians having examined the patient and exercising reasonable medical judgment, will result in death within six months, or a condition in which the patient has been determined in writing by two physicians as having no reasonable probability of recovery from an irreversible coma or persistent vegetative state.

(8) "Adult person" means a person attaining the age of majority as defined in RCW 26.28.010 and 26.28.015.

(9) "Aid-in-dying" means aid in the form of a medical service provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the

time the medical service is to be provided.

Sec. 3. Section 4, chapter 112, Laws of 1979 and RCW 70.122.030 are each amended to read as follows:

(1) Any adult person may execute at any time a directive directing the withholding or withdrawal of life-sustaining procedures and/or requesting the provision of aid-in-dying when in a terminal condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded to the health facility upon the withdrawal of life-sustaining procedures, and/or provision of aid-in-dying. No person shall be required to execute a directive in accordance with this chapter. Any person who has not executed such a directive is ineligible for aid-in-dying under any circumstances. The directive shall be essentially in the following form, but in addition may include other specific directions:

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____(month, year).

I_____, being of sound mind, wilfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death ((~~and where my physician determines that my death is imminent whether or not life sustaining procedures are utilized~~)).

Declarant must initial one or both of the following:

____I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.

____I direct that upon my request my physician provide aid-in-dying so that I might die in a dignified, painless and humane manner.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining procedures, such as while in an irreversible coma or persistent vegetative state, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal.

(c) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

(d) I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

(e) I understand that I may add to or delete from or otherwise change the wording of this directive before I sign it, and that I may revoke this directive at any time.

Signed_____

City, County and State of Residence.

The declarer has been personally known to me and I believe him or her to be of sound mind.

Witness_____

Witness_____

(2) Prior to effectuating a directive the diagnosis of a terminal condition by two physicians shall be verified in writing, attached to the directive, and made a permanent part of the patient's medical records.

(3) Similar directives to physicians lawfully executed in other states shall be recognized within Washington state as having the same authority as in the state where executed.

Sec. 4. Section 5, chapter 112, Laws of 1979 and RCW 70.122.040 are each amended to read as follows:

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the

declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revodation [sic] shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal, civil, or administrative liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

Sec. 5. Section 6, chapter 112, Laws of 1979 and RCW 70.122.050 are each amended to read as follows:

No physician or health facility which, acting in good faith in accordance with the requirements of this chapter, causes the withholding or withdrawal of life-sustaining procedures from a qualified patient, shall be subject to civil liability therefrom. No licensed health personnel, acting under the direction of a physician, who participates in good faith in the withholding or withdrawal of life-sustaining procedures in accordance with the provisions of this chapter shall be subject to any civil liability. No physician,

or licensed health personnel acting under the direction of a physician, or health facility ethics committee member who participates in good faith in the withholding or withdrawal of life-sustaining procedures and no physician who provides aid-in-dying to a qualified patient in accordance with the provisions of this chapter shall be subject to prosecution for or be guilty of any criminal act or of unprofessional conduct.

Sec. 6. Section 7, chapter 112, Laws of 1979 and RCW 70.122.060 are each amended as follows:

(1) Prior to effectuating a withholding or withdrawal of life-sustaining procedures from or provision of aid-in-dying to a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW 70.122 .030 and, if the patient is mentally competent, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining procedures and/or the provision of aid-in-dying. No physician, and no licensed health personnel acting in good faith under the direction of a physician, shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection, and no health facility may be required to permit the provision of aid-in-dying within its facility. If the physician or health care facility refuses to effectuate the directive, such physician or facility shall make a good faith effort to transfer of the qualified patient to another physician who will effectuate the directive of the qualified patient or to another facility.

Sec. 7. Section 8, chapter 112, Laws of 1979 and RCW 70.122.070 are each amended to read as follows:

(1) The withholding or withdrawal of life-sustaining procedures from or the provision of aid-in-dying to a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide.

(2) The making of a directive pursuant to RCW 70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining procedures from or the provision of aid-in-dying to an insured qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility, or other health provider, and no health service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

Sec. 8. Section 10, chapter 112, Laws of 1979 and RCW 70.122.080 are each amended to read as follows:

The act of withholding or withdrawing life-sustaining procedures or providing aid-in-dying, when done pursuant to a directive described in RCW 70.122.030 and which causes the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of any person that placed the declarer in a terminal condition and the death of the declarer.

Sec. 9. Section 9, chapter 112, Laws of 1979 and RCW 70.122.090 are each amended to read as follows:

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another

without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040, with the intent to cause a withholding or withdrawal of life-sustaining procedures or the provision of aid-in-dying contrary to the wishes of the declarer and thereby, because of any such act, directly causes life-sustaining procedures to be withheld or withdrawn or aid-in-dying to be provided and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030.

Sec. 10. Section 11, chapter 112, Laws of 1979 and RCW 70.122.100 are each amended to read as follows:

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying and to permit death with dignity through the provision of aid-in-dying only by a physician when voluntarily requested in writing as provided in this chapter by a conscious and mentally competent qualified patient at the time aid-in-dying is to be provided.

Sec. 11. Section 1, chapter 112, Laws of 1979 and RCW 70.122.900 are each amended to read as follows:

This act shall be known and may be cited as the "((~~Natural~~)) Death With Dignity Act."

NEW SECTION. Sec. 12. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

APPENDIX I

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	No. C94-119
Plaintiffs,	)	JUDGMENT
v.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

Pursuant to 28 U.S.C. 2201, declaratory judgment is hereby entered in favor of plaintiffs Harold Glucksberg, M.D., Abigail Halperin, M.D., Thomas A. Preston, M.D., and Peter Shalit, M.D., Ph.D. insofar as they raise claims

on behalf of their terminally ill patients, and in favor of plaintiffs Jane Roe, John Doe and James Poe, as follows:

RCW 9A.36.060 is unconstitutional because it places an undue burden on the exercise of a protected Fourteenth Amendment liberty interest by terminally ill, mentally competent adults acting knowingly and voluntarily, without undue influence from third parties, who wish to commit physician-assisted suicide. Further, RCW 9A.36 .060 is declared unconstitutional because it violates the right to equal protection under the Fourteenth Amendment by prohibiting physician-assisted suicide while permitting the refusal or withdrawal of life support systems for terminally ill individuals.

Entered at Seattle, Washington this 20th day of May, 1994.

/s/
BARBARA J. ROTHSTEIN
CHIEF UNITED STATES
DISTRICT JUDGE

Presented by:
PERKINS COIE

By: /s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

CHRISTINE O. GREGOIRE
ATTORNEY GENERAL

By: /s/
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Washington and Christine O. Gregoire,
Attorney General of Washington

APPENDIX J

Supreme Court of the United States

No.
A-974

WASHINGTON, ET AL.,
Applicants,
v.
HAROLD GLUCKSBERG, M.D., ET AL.,

ORDER

UPON CONSIDERATION of the application of counsel for the applicants,

IT IS ORDERED that the mandate of the United States Court of Appeals for the Ninth Circuit, case No. 94-35534, issued on May 29, 1996, be recalled and stayed pending receipt of a response, due on or before June 5, 1996, and further order of the undersigned or of the Court.

/s/ Sandra D. O'Connor
Associate Justice of the Supreme
Court of the United States

Dated this 29th
day of May, 1996

APPENDIX K

Supreme Court of the United States

MONDAY, JUNE 10, 1996

No.

A-974

WASHINGTON, ET AL.,

Applicants,

v.

HAROLD GLUCKSBERG, M.D., ET AL.,

ORDERS IN PENDING CASES

The application for a stay of the issuance of the mandate of the United States Court of Appeals for the Ninth Circuit, case No. 94-35534, issued on May 29, 1996, presented to Justice O'Connor and by her referred to the Court is granted pending the timely filing and disposition by this Court of a petition for writ of certiorari. Should the petition for a writ of certiorari be denied, this stay terminates automatically. In the event the petition for a writ of certiorari is granted, this stay shall continue pending the sending down of the judgment of this Court.

Supreme Court, U.S.
FILED
AUG 16 1996
CLERK

No. 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM 1995

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Should this Court grant certiorari to decide whether the Fourteenth Amendment's guarantee of liberty protects the decision of a mentally competent, terminally ill adult to hasten impending death in a certain, humane, and dignified manner when

1. the only federal appellate court other than the Ninth Circuit to consider the constitutional validity of a statute prohibiting assisted suicide also struck down the prohibition as constitutionally infirm;

2. the single conflicting state court decision on the validity of a statute prohibiting assisted suicide addresses different facts and a statute that has expired;

3. the law continues to be developed by the lower courts; and

4. the Ninth Circuit properly applied this Court's due process precedent?

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IN THE

Supreme Court of the United States

OCTOBER TERM 1995

No. 96-110

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

STATEMENT OF THE CASE

I. FACTUAL BACKGROUND

The State of Washington allows individuals to commit suicide and recognizes a liberty interest in choosing to end a painful and futile existence, at least where that can be done by terminating medical treatment. On the other hand, the State makes it a crime for any person to assist in any way, other than the removal of life-sustaining treatment, in a terminally

ill, mentally competent person's choice to hasten inevitable death and end suffering.

Respondents contend that the United States Constitution's guarantee of liberty protects the right of competent, terminally ill adults to choose to hasten inevitable death and that this necessarily entails medical assistance — in particular, drugs prescribed for that purpose. In addition, respondents contend that the exception to Washington's prohibition, recognized by court and legislature, in the case of persons who can choose to hasten death by directing the termination of medical treatment violates the Equal Protection Clause.

The record in this case establishes the following undisputed facts regarding the original patient plaintiffs and respondents:

At the time this case was filed, Dr. Jane Roe, 69, was dying of breast cancer.[1] Her cancer had metastasized widely into her bones and was growing rapidly throughout her entire skeleton. She had undergone surgery, chemotherapy, and radiation therapy, but the cancer prevailed. Dr. Roe suffered chronic, intractable pain, which she attempted to alleviate with large and increasing doses of morphine; however, she still experienced frequent and severe pain. Dr. Roe was confined to bed for the seven months prior to the filing of this action. Movement was intensely painful, and her weakened muscles could not support her. She was anemic, incontinent, and vulnerable to infections.

Dr. Roe was a mentally competent retired physician. She had been advised and understood that there was no chance of recovery and that despite excellent medical care she faced severe and unrelenting suffering. Dr. Roe wished to hasten her

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[1] Dr. Roe died prior to the district court's decision. *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (9th Cir. 1996) (en banc).

inevitable death by taking drugs of a type and in an amount prescribed by her doctor for that purpose. *Compassion*, 79 F.3d at 794-95.

At the time this action was filed, John Doe, 44, was dying of AIDS.[2] His doctors had advised him that there was no chance of recovery and that he faced severe and continuous suffering. John Doe was vulnerable to all manner of infections with almost no natural ability to fight them. Mr. Doe had cytomegalovirus retinitis, which caused him to lose approximately 70% of his vision at the time this action was filed and was anticipated to result in complete blindness. Loss of vision was fatal to Mr. Doe's vocation and avocation, painting. Mr. Doe had been hospitalized for AIDS-related pneumonia on several occasions, suffered from chronic skin infections, sinusitis, and grand mal seizures related to AIDS, and experienced extreme fatigue and a rapidly diminishing ability to care for himself. Mr. Doe had served as the primary caregiver for his long-term companion who died of AIDS at home in Mr. Doe's care. Mr. Doe witnessed firsthand the pain, suffering, and loss of bodily function, integrity, and personal dignity the disease causes at the end of life.

John Doe was mentally competent and understood his diagnosis and prognosis. John Doe wished to hasten his inevitable death by taking drugs of a type and in an amount prescribed by his doctor for that purpose. *Id.*

At the time this case was filed, James Poe, 69, was dying of chronic, end-stage emphysema.[3] His doctors had advised

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[2] Mr. Doe died prior to the district court's decision. *Compassion*, 79 F.3d at 794-95.

[3] Mr. Poe died prior to the decision by the three-judge panel of the Ninth Circuit. *Compassion*, 79 F.3d at 794-95.

him that his future held no chance of recovery, only terrible pain and suffering. Every breath was a struggle. He was supplied oxygen through a tube to his nose 24 hours a day and spent hours each day aspirating medications to facilitate breathing. He was terrified by his inability to get enough air. He regularly took medications, including morphine, to calm the panic associated with the sensation of suffocation. He also suffered from associated heart failure, which resulted in painful swelling of his extremities and loss of mobility.

James Poe was mentally competent and understood his diagnosis and prognosis. James Poe desired the right to choose to hasten his inevitable death by taking drugs of a type and in an amount prescribed by his doctor for that purpose when his suffering became unbearable. *Id.*

Respondents Glucksberg, Halperin, Preston, and Shalit are physicians who regularly treat terminally ill patients. Each encounters mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and who desire physician assistance in hastening their deaths to avoid prolonged suffering. Each encounters cases in which his or her professional responsibilities dictate that he or she honor mentally competent, terminally ill patients' requests for medication to hasten death. The physicians present both their own claims and the claims of their patients in this action.[4] *Id.* at 794-96.

In the physicians' professional judgment, the desire of such patients to hasten inevitable death and avoid suffering can be rational. In these cases the appropriate procedure is to ensure competence, to confirm the terminal diagnosis, and to

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[4] The Ninth Circuit correctly held that the physicians had standing to present the claims of their patients. *Compassion*, 79 F.3d at 795-96. *See Doe v. Bolton*, 410 U.S. 179, 187-89 (1973).

prescribe the proper drugs that will allow the patient to decide whether to live, and suffer, any longer. It was undisputed below that patients who cannot receive this medical assistance cannot hasten their deaths in a certain and humane manner and that some cannot hasten their death in any manner without such assistance. The physicians, however, know that prescribing drugs for this purpose exposes them to criminal prosecution under RCW 9A.36.060. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1457-58 (W.D. Wash. 1994).

II. THE LOWER COURTS' DECISIONS

Respondents concur in petitioners' statement of the proceedings below.

REASONS FOR DENYING THE PETITION

I. THERE IS NO CONFLICT AMONG THE LOWER COURTS

A. There Is No Conflict Between Federal Circuits

Aside from the Ninth Circuit, the only other federal appellate court to consider the issues presented in this case is the Second Circuit, which also determined that mentally competent, terminally ill patients are constitutionally entitled to seek physician assistance in hastening death in the form of medications prescribed for that purpose. *Quill v. Vacco*, 80 F.3d 716, 727 (2d Cir. 1996), *petition for cert. docketed*, 65 U.S.L.W. 3052 (May 16, 1996) (No. 95-1858). In its decision, the Second Circuit struck down statutes similar to the Washington statute challenged in this case.

Both the Second Circuit and the Ninth Circuit were presented with Fourteenth Amendment liberty and equal protection claims. The Ninth Circuit found that the right to physician assistance in hastening death fell within the bounds

of the liberty interest demarcated by this Court in the reproductive rights cases and *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990). *Compassion*, 79 F.3d at 813-16. Having found a protected liberty interest, the Ninth Circuit declined to address the equal protection claim. *Id.* at 838.[5]

In a unanimous decision, the Second Circuit ruled that New York's law prohibiting physician-assisted suicide violates the Equal Protection Clause. *Quill*, 80 F.3d at 727. The Second Circuit briefly considered the liberty claim and declined to find a constitutionally protected liberty interest absent explicit guidance from this Court.[6]

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[5] Because there is no equal protection ruling to review, the third question presented by petitioners — whether a rational basis exists for distinguishing between the refusal and withdrawal of life-sustaining treatment and the provision of lethal medication such that equal protection guarantees are not impinged — and the related discussion (Petition at 22-26) are not before this Court and cannot be a basis for discretionary review.

Nevertheless, in considering the equal protection issue it is fair to recognize that the Ninth Circuit appreciated the lack of an "ethical or constitutionally cognizable" basis upon which to distinguish between physician assistance in hastening death by the act of prescribing medications for that purpose and the act of withdrawing or withholding life support. *Compassion*, 79 F.3d at 821-24. This recognition is consistent with the reasoning of the only other federal circuit to consider the issue. *See Quill*, 80 F.3d at 727.

[6] The Second Circuit's reluctance to find a liberty interest was premised upon its conclusion that *Bowers v. Hardwick*, 478 U.S. 186 (1986), directed lower courts to refrain from recognizing previously unrecognized liberty interests, even where this Court's analytical standards have been met. *Quill*, 80 F.3d at 725 ("Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area.").

Thus, there is no conflict in the results reached by the two federal appellate courts that have considered the constitutionality of state laws that operate to prevent mentally competent, terminally ill adults from choosing to hasten death in a certain, humane, and dignified manner. Rather, there is simply a distinction between the constitutional grounds employed to reach the same result. There is no need for this Court to referee such a theoretical "conflict."

B. There Is No True Conflict Between a Federal Court and a State Court of Last Resort

The Michigan Supreme Court ruling identified by petitioners as giving rise to a conflict is meaningless for purposes of this Court's decision whether to grant review. *See People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).[7]

Hardwick did not stand for the absolute admonition perceived by the Second Circuit. As the Ninth Circuit noted, *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992), explicitly reiterates the principle that the fact that a right has not previously been recognized is no barrier to its recognition. *Compassion*, 79 F.3d at 805. This principle was again reaffirmed just this past term in *United States v. Virginia*, 64 U.S.L.W. 4638, 4650 (June 26, 1996) ("A prime part of the history of our Constitution . . . is the story of the extension of constitutional rights and protections to people once ignored or excluded."), and is also evident from the rulings subsequent to *Hardwick* that *have* recognized previously unrecognized liberty interests or reaffirmed previously recognized liberty interests. *See, e.g., Casey*, 505 U.S. 833 (reaffirming the liberty interest in terminating a pre-viable pregnancy); *Cruzan*, 497 U.S. 261 (recognizing a liberty interest in the deeply personal area of end-of-life decision-making); *Washington v. Harper*, 494 U.S. 210 (1990) (recognizing a liberty interest in being free from the arbitrary administration of antipsychotic drugs).

[7] The only other decision that petitioners rely on as creating a conflict on the liberty issue is a state appellate court decision. Petition at 21.

First, the consolidated cases involving Dr. Jack Kevorkian did not involve the narrow liberty interest recognized here. Dr. Kevorkian's assistance in the deaths of patients has not been limited either to mentally competent or to terminally ill patients, much less patients who are both competent and terminally ill.

Second, the Michigan statute reviewed by the Michigan Supreme Court has since expired by its own terms. Mich. Comp. Laws § 752.1027. Thus, any conflict that existed has evaporated. This point was made by the State of Michigan itself in its opposition to a petition for writ of certiorari: "The challenged statute no longer exists. In these circumstances, an order declaring its unconstitutionality and enjoining its enforcement would be meaningless." *Hobbins v. Michigan*, No. 94-1473 (October Term 1994), Brief for Respondent in Opposition at 13.

Finally, the need for review by this Court is less than compelling where, as here, a state court ruling that refuses to recognize federal constitutional rights is followed by federal court rulings that consistently protect the asserted federal constitutional rights.

Without even discussing the patently distinguishable nature of that case, it simply does not create a conflict worthy of this Court's attention. Supreme Court Rule 10.1(a).

Petitioners' attempt to create a conflict between the decision below and various state court decisions on the equal protection issue (Petition at 25-26) is misleading. *See supra* note 5. None of the state court decisions involved the constitutional claim of mentally competent, terminally ill adults to choose a humane hastened death by means of self-administering medications prescribed for that purpose. None of the cases reviewed discrimination in that context or held that there is no such equal protection right.

II. REVIEW BY THIS COURT AT THIS TIME IS PREMATURE

In an effort to obtain review, petitioners identify a variety of broad ramifications that may flow from the Ninth Circuit's decision. Petition at 10-11. In fact, however, most of the issues raised, which petitioners themselves argue require consideration by this Court, were not finally resolved by the Ninth Circuit. Issues surrounding patient choice and physician assistance in hastening death continue to be reviewed by lower courts. For example, respondents are aware that at least one case raising similar issues is pending. *McIver v. Krischer*, CL96-1504AF, Palm Beach Circuit Court, 15th Judicial Circuit, Florida.

Sound principles of judicial restraint counsel against granting review at this time. As recognized in *McCray v. New York*, 461 U.S. 961, 963 (1983), denial of certiorari is proper where an issue requires "further study" in lower courts "before it is addressed by this Court." Moreover, this Court need not grant review simply because an issue is important. *See, e.g., Texas v. Hopwood*, 64 U.S.L.W. 3868 (July 1, 1996) (certiorari denied notwithstanding fact that case presented important constitutional questions); *Gilliard v. Mississippi*, 464 U.S. 867, 869 (1983) (Marshall, J., dissenting from denial of certiorari to "those of my colleagues who agree with me that . . . these cases present important constitutional questions, but believe that this Court should postpone consideration of the issue until more state supreme courts and federal circuits have experimented with substantive and procedural solutions to the problem"); *California ex rel. Cooper v. Mitchell Bros.' Santa Ana Theater*, 454 U.S. 90, 98 (1981) (Stevens, J., dissenting from grant of certiorari on

grounds of traditional practice of avoiding premature adjudication of constitutional principles).[8]

III. THE NINTH CIRCUIT CORRECTLY DECIDED THAT WASHINGTON'S PROHIBITION OF ASSISTED SUICIDE VIOLATES THE FOURTEENTH AMENDMENT'S GUARANTEE OF LIBERTY

The Ninth Circuit carefully reviewed this Court's substantive due process precedent and correctly applied principles developed in those cases. Although petitioners would like to cabin the principles recognized by this Court in the reproductive rights and withdrawal of life support cases to those specific factual contexts, there is no principled way to do so. As the court below recognized, this Court "has carved out certain key moments and decisions in individuals' lives and placed them beyond the general prohibitory authority of the state." *Compassion*, 79 F.3d at 812-13 (citing *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (child rearing and education); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (whether to bear or beget a child); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion)). *See also Zablocki v. Redhail*, 429 U.S. 1089

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[8] Denial of review at this time, of course, would suggest no expression upon the merits of the case. *See, e.g., Maryland v. Baltimore Radio Show, Inc.*, 338 U.S. 912, 919 (1950); *United States v. Carver*, 260 U.S. 482, 490 (1923).

The absence of true conflict and the prematurity of review might be overlooked if the Ninth Circuit had clearly gone astray. But, as discussed below, that is not the case. The Ninth Circuit acted en banc and eleven respected judges carefully and exhaustively addressed the issue. Only three judges dissented. Moreover, all three judges on the Second Circuit concurred with the result reached by the Ninth Circuit.

(1977) (marriage); *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (family living arrangements). The constitutional tenets developed in these cases are of general application. They can and must be applied to the facts of this case.

A. *Cruzan* Supports the Liberty Interest Recognized Below

The pertinent principle recognized in *Cruzan* is that decisions regarding the end of one's life are "deeply personal" and should be safeguarded from usurpation. 497 U.S. at 281. That principle directly applies here. When a dying patient is mentally competent, as all of the patients represented in this case were and are, and is able to make known his or her wishes regarding the continuation of life, these wishes are entitled to respect and are protected against blanket state suppression.[9]

Ignoring the basic test for determining the existence of a liberty interest set forth by the Court in *Cruzan*, petitioners leap to language in the opinion that suggests a countervailing state interest in preserving life. Petitioners point out that this interest is reflected in state laws banning assisted suicide. Petition at 14. This Court's recognition of a general state interest in preserving life, however, does not suggest that the weight of that interest is the same in cases where a patient is at the threshold of death due to the progress of terminal disease as it is in cases involving the preservation of life for the general population.

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[9] Thus, the real question is whether any state interest outweighs the patient's interest. The Ninth Circuit properly concluded that the state's interests do not outweigh the mentally competent, terminally ill patient's liberty interest in choosing to hasten impending death in a humane and dignified manner. *Compassion*, 79 F.3d at 816-37.

No judgment by the state as to the *quality* of such a patient's life is necessary to recognize that the state's interest does not outweigh the patient's when the patient is terminally ill and mentally competent. This case is limited to patients with a severely diminished life expectancy — a limited *quantity* of life — due to the advance of disease. In recognizing that the state's interest in preserving life is "substantially diminished" in the terminal phase of illness, the court below provided a construct under which relative state and patient interests may be weighed. *Compassion*, 79 F.3d at 820. Petitioners' concern that the court provided no structure (Petition at 15) is unwarranted.

The principle that the state's interest in preserving life weakens as the patient's prognosis dims has been recognized since the seminal case of *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976). This concept is fully consistent with the principle, well established in the reproductive rights cases, that, as the potential for life increases, the state's interest in preserving life increases. *See, e.g., Casey*, 505 U.S. at 846, 860; *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 516 n.14 (1989); *Roe v. Wade*, 410 U.S. at 163.

B. The Reproductive Rights Cases Support the Liberty Interest Recognized Below

The reproductive rights cases, among others, recognize that "there is a realm of personal liberty which the government may not enter." *Casey*, 505 U.S. at 847. These cases acknowledge that decisions concerning one's own body, one's own medical care, and one's own future life course fall within that realm. *See, e.g., id.* at 851. The considerations that led to this conclusion in the reproductive rights context are plainly present in the end-of-life context as well.

The decision regarding the end of one's life is even more personal and significant to an individual than the decision regarding reproduction. Indeed, eight Ninth Circuit judges agreed that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain," *Compassion*, 79 F.3d at 813, and that "no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end." *Id.* at 837. The court further recognized that

> Prohibiting a terminally ill patient from hastening his death may have an even more profound impact on that person's life than forcing a woman to carry a pregnancy to term. . . . For such patients, wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture. Surely, a person's decision whether to endure or avoid such an existence constitutes one of the most, if not the most, "intimate and personal choices a person may make in a life-time," a choice that is "central to personal dignity and autonomy."

Id. at 814 (quoting *Casey*, 505 U.S. at 851).[10]

The judgment below properly followed *Casey*'s direction that a state may regulate to protect its legitimate interests, and

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[10] The district court also recognized this: "the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman." *Compassion*, 850 F. Supp. at 1460.

explicitly recognized that the state may protect its interests by regulation of the practice of physician-assisted suicide. *Compassion*, 79 F.3d at 816 ("[W]e explicitly recognize that some prohibitory and regulatory state action is fully consistent with constitutional principles."); *id.* at 833 ("[T]he state should enact regulatory measures that ensure . . . that all necessary safeguards have been provided."); *id.* at 837 ("[T]he process itself [of physician-assisted suicide] can be carefully regulated and rigorous safeguards adopted.").

Petitioners' suggestion that *Casey* is nothing more than a creature of stare decisis is disrespectful to the agonizing effort in *Casey* to craft a reliable middle course for the future and to the values that inform the stare decisis doctrine. The Court in *Casey* did not just blindly apply *Roe v. Wade*; it analyzed fully the constitutional arguments and resolved them with logic that applies with full force to this case. Petitioners' offhand approach in no way avoids the fact that stare decisis requires the application of *Casey* to cases that raise issues it addresses.[11]

C. Petitioners' Overstatement of the Scope of the Decision Below Is Misguided

As noted above, without a conflict to merit review, petitioners resort to the alarmist tactic of overstating the scope of the Ninth Circuit's decision in order to suggest that terrible

[11] Petitioners' argument that abortion is a "unique" act (Petition at 17) does not advance their position. The "unique" aspect of abortion is the decision to terminate a potential life that has no voice in the decision. The related interests and concerns that make the abortion issue difficult and complex are absent here. Foremost among these, the interest of the separate "life that is aborted," *Casey*, 505 U.S. at 852, has no counterpart in the decision of a dying person to hasten his or her own death.

consequences will flow from it.[12] Petitioners suggest that the court's decision affirmatively permits (1) assistance by non-physicians; (2) patients to choose to hasten death solely out of financial motivation; (3) surrogates to direct the hastened death of a mentally incompetent patient; and (4) physician assistance in a form other than prescribing medications for patient self-administration. Petition at 10-11. Each of these contentions is flawed, but they exemplify the wisdom of allowing further development of the law in the lower courts.

1. Assistance by Non-Physicians

In recognizing that a mentally competent, terminally ill patient has a right to choose a certain, humane, and dignified death by self-administering medications prescribed for that purpose, the court below appropriately acknowledged that ancillary actors "whose services are essential" to the exercise of this option "and who act under the supervision or direction of a physician are necessarily covered by our ruling." *Compassion*, 79 F.3d at 838 n.140.

Given the broad wording of the challenged statute, this was necessary to permit patients to exercise the right recognized. The actors within this protected sphere are specifically described and include the pharmacist filling the prescription, the health care workers facilitating the patient's request, and family or loved ones doing such minor acts as

[12] This tactic is often employed by those opposing the recognition of constitutional rights. *See, e.g., United States v. Virginia*, 64 U.S.L.W. at 4645-46 (reviewing history of opposition to women's admission to military schools and observing that none of the forecast terrible consequences had actually occurred).

providing liquid with which to swallow pills.[13] Nothing in the decision below indicates that non-physicians would be empowered to otherwise assist a suicide or provide the means for hastening death.[14]

2. Financial Motivation

The notion that the decision below establishes a liberty interest in hastening death for financial reasons is specious. The Ninth Circuit recognized simply that, among many factors, a patient might consider the economic welfare of his or her family. Current law permits patients to choose to hasten death by refusing (or directing the withdrawal of) life support, notwithstanding the fact that the decision might be motivated by financial concerns. It is not at all clear why the same ability to consider family finances in end-of-life decision-

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[13] Allowing loved ones to be present with the patient at the time he or she hastens impending death eliminates the terrible tragedy of forcing patients who choose to hasten death to act, and die, alone. *See, e.g.*, Timothy E. Quill, *A Case of Individualized Decision-Making*, 324 N. Eng. J. Med. 691, 694 (1991) ("I wonder whether the image of Diane's final aloneness will persist in the minds of her family. . . . I wonder why Diane, who gave so much to so many of us, had to be alone for the last hour of her life.")

[14] In the abortion context, this Court has held that non-physicians who provide abortions could be subject to prosecution. *Connecticut v. Menillo*, 423 U.S. 9 (1975) (criminal abortion statutes can continue to be enforced against non-physicians). The abortion cases and the entire history of restricting the practice of medicine and the power to prescribe medications demonstrate that legislatures have the capacity to use physician-only requirements to protect individuals from abuse. Although it is difficult to determine when such requirements are appropriate, the abortion cases hold that blanket state prohibitions may not deny doctors the freedom to respond to requests from competent patients in narrowly tailored circumstances. Any consideration of broader claims is premature at this juncture.

making should not be available for patients whose conditions do not involve life-sustaining treatment.[15]

3. Surrogate Decision-Making for Mentally Incompetent Patients

This case involves only the claims of mentally competent, terminally ill patients, and the Ninth Circuit addressed only the claims of such patients.[16] Contrary to the suggestion of petitioners, however, existing law regarding patients who have lost mental competency does not permit surrogates to make all of the decisions that a competent person could make. For example, a competent patient could direct the withdrawal of life support, regardless of whether he or she was terminally ill. This was the holding in *Cruzan*. By contrast, under Washington law a surrogate can direct the withdrawal of life support from a patient *only* when the patient either is terminally ill or has become permanently unconscious, and

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[15] A physician requested to assist in hastening the death of a patient will necessarily inquire into the patient's motivation. In the case of a terminal patient who is neither suffering nor experiencing pain, a physician might well question the competency of a patient making such a request. In addition, safeguards could be set by the legislature to ensure that decisions to hasten death are not the product of coercion.

[16] The court below explicitly limited the protected interest to mentally competent patients. *Compassion*, 79 F.3d at 793 ("We hold that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment."); *id.* at 834 ("[W]hen a mentally competent adult is terminally ill, and wishes, free of any coercion, to hasten his death because his remaining days are an unmitigated torture, that person's liberty interest is at its height."); *id.* at 837 ("[W]e hold that the 'or aids' provision of Washington statute RCW 9A.36.060 is unconstitutional as applied to terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians.").

only following requisite confirmation of the patient's condition. *In re Grant*, 109 Wn.2d 545, 747 P.2d 445 (1987) (surrogate may direct withdrawal of life support when patient is terminally ill); *In re Hamlin*, 102 Wn.2d 810, 689 P.2d 1372 (1984) (surrogate may direct withdrawal of life support when patient is permanently unconscious).[17] The language cited by petitioners simply recognizes that once a surrogate is empowered to act on behalf of a patient, the decision of the surrogate "is for all legal purposes the decision of the patient himself." *Compassion*, 79 F.3d at 832 n.120.

4. Expansion to Other Forms of Assistance

Far from "telegraphing the possibility" of the expansion of medical assistance in hastening death to euthanasia, Petition at 10, the Ninth Circuit explicitly stated: "[W]e place euthanasia, as we define it, on the opposite side of the constitutional line we draw for purposes of this case . . . ." *Id.* In the constitutional balancing of state and patient interests, the state would appear to be able to articulate significantly greater interests in the case of physician-administered lethal medications.

D. The Ninth Circuit's Analysis of the As Applied Challenge Is Correct

This case focuses on specific conduct by individuals with distinguishing characteristics: the decision of mentally competent, terminally ill adults to hasten death by self-administering medications prescribed for that purpose. This

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[17] Although the issue was not before the court below, *Cruzan* instructs that if a future case presented the question of a surrogate's ability to direct a hastened death for an incompetent patient, the state's interest in protecting against the usurpation of the personal element of patient choice might well outweigh the asserted interest of the patient.

constitutional challenge was brought because Washington's statute criminalizes the action of a physician assisting a patient in the exercise of this choice. As such, the statute operated to prevent patient plaintiffs Roe, Doe, and Poe — and operates to prevent the mentally competent, terminally ill patients of the physician plaintiffs/respondents — from exercising the option of a humane hastened death. Likewise, those doctors are prevented from providing the care and assistance necessary for their mentally competent, terminally ill patients to exercise this personal choice. *Id.* at 794-95.

Thus, petitioners' contention that this case does not involve the application of the challenged statute to "identified individuals" or "particular fact situations" (Petition at 19) is patently untrue.[18] The court below properly considered whether the application of the challenged statute to the individuals identified above infringed a constitutionally protected right and held that it did.[19] Because the Ninth Circuit resolved this case as an as applied challenge, the *Salerno* test for some facial challenges has no application here and does not create an issue for review by this Court.[20]

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[18] Petitioners in effect suggest that any suit for anticipatory relief is a facial challenge because it necessarily involves some degree of speculation. This is not, nor has it ever been, the conventional understanding of a facial challenge.

[19] Having found the statute unconstitutional as applied to these identified individuals, the court below indicated that the constitutional infirmity would exist in the case of individuals similarly situated as well. *Compassion*, 79 F.3d at 798 n.9.

[20] The Ninth Circuit correctly noted that even if the facial validity of the statute had been ruled on, the *Salerno* test, as articulated in *United States v. Salerno*, 481 U.S. 739, 745 (1987), would not have been applicable. *Compassion*, 79 F.3d at 798 n.9 ("[W]e believe that the

E. The Proper Respective Roles for the Judiciary and the Legislature Are Respected in the Decision Below

Petitioners' argument that the protection of this liberty interest should be left to the legislative process (Petition at 26-28) is fundamentally misguided. Where constitutional rights are infringed it is the essential purpose of the judiciary to protect those rights against majority will and the political process. *See, e.g., Schweiker v. Wilson*, 450 U.S. 221, 230 (1981) (where the democratic process impinges on constitutional rights, "the judiciary then has a duty to intervene in the democratic process"); *Marshall Field & Co. v. Clark*, 143 U.S. 649, 670 (1892) (recognizing "duty of this court, from the performance of which it may not shrink, to give full effect to the provisions of the Constitution"); *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).[21] As the Ninth Circuit painstakingly delineated, the decision at issue is a highly personal one that must be left to the individual and protected by the courts from legislative action that intrudes excessively into the decision-making realm. The court reiterated the time-honored principle: "The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power." *Compassion*, 79 F.3d at 839. On the basis of that constitutional mandate, the Ninth Circuit concluded: "Under our constitutional system, neither the state

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Salerno test would not in any event be the appropriate one for adjudicating a facial challenge to Washington's prohibition on assisted suicide.").

[21] None of the cases cited by petitioners (Petition at 27-28) suggest otherwise. Those cases deal exclusively with the regulation of industrial and business conditions, not the suppression of individual liberties. Moreover, those cases recognize that states do not have the power to regulate even commercial affairs when their laws "run afoul of" the Constitution. *See, e.g., Ferguson v. Skupra*, 372 U.S. 726, 729-31 (1963).

nor the majority of the people in a state can impose its will upon the individual in a matter so highly 'central to personal dignity and autonomy.'" *Id.* (quoting *Casey*, 505 U.S. at 851).

CONCLUSION

The judgment below does not present a conflict that merits review by this Court, and review at this time would be premature. The Court has recognized that the constitutional right of liberty stands as a barrier against laws that deny individuals the right to make the most fundamental choices affecting their values and lives. The Ninth Circuit correctly applied this Court's precedent in finding that the Fourteenth Amendment protects the liberty to choose between a tortured death and a humane one, while at the same time recognizing the role of legislative involvement in crafting safeguards to protect the legitimate state interests. For these reasons, the Court should deny the Petition for Writ of Certiorari.

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IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners/Defendants,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents/Plaintiffs.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

REPLY TO OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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I. RESPONDENTS' ATTEMPTS TO EXPLAIN AWAY CLEAR CONFLICTS BETWEEN THE DECISION BELOW AND THOSE OF OTHER FEDERAL AND STATE COURTS ARE FACILE, BUT INEFFECTIVE

Plaintiffs argue that no conflict exists between the unprecedented decision below and the decisions of both federal and state appellate courts that have reached a different conclusion than did the Ninth Circuit. Opp'n at 5-9. They are wrong.

A. The Second Circuit Conflict

The Ninth Circuit concluded below that mentally competent, terminally ill patients have interests under the Due Process Clause that include physician assistance in ending their lives. App. A-116. As pointed out in the Petition, the Second Circuit has explicitly rejected this conclusion.

> "The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death."

Quill v. Vacco, 80 F.3d 716, 724-25 (2d Cir. 1996), *petition for cert. docketed*, 65 U.S.L.W. 3052 (May 16, 1996) (No. 95-1858).

The Second Circuit's decision, issued 27 days *after* that of the Ninth Circuit, presents a direct conflict with the decision below. Contrary to Plaintiffs' argument, the conflict is not lessened by the fact that the Second Circuit developed a different approach—under the Equal Protection

Clause—as a basis to strike down New York statutes prohibiting assisted suicide.[1]

Nor is the conflict lessened by the Second Circuit's recognition that this Court's prior opinions, combined with the Second Circuit's "position in the judicial hierarchy", dictated that it "be even more reluctant than the [Supreme] Court to undertake an expansive approach in this unchartered area". *Quill*, 80 F.3d at 725.

The Ninth Circuit, of course, showed no such reluctance. The decision below is broad in both language and import, creating a new approach to liberty interest analysis under the Due Process Clause and imposing new limitations on state legislative discretion in making public policy decisions. Notwithstanding the similarity of result reached by the two panels, their approaches present a significant conflict, one only this Court can resolve.

B. The Michigan Supreme Court Conflict

Plaintiffs do not deny that the decision below conflicts with that of the Michigan Supreme Court in *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied* 115 S. Ct. 1795 (1995). Rather, they claim that the conflict has "evaporated" because "the statute reviewed by the Michigan Supreme Court has since expired by its own terms". Opp'n at 8. An examination of the *Kevorkian* opinion reveals that Plaintiffs' argument is without merit.

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[1] The diversity of approaches taken by the Second and Ninth Circuits to get to similar results doesn't necessarily strengthen either court's decision. "The fact that the courts could not even agree on which part of the constitution creates the 'right to die' exposes the shaky basis of both arguments." *A faint message from the founders*, The Economist, April 20, 1996, at 19.

The Michigan Supreme Court opinion addressed four cases. Three of the four involved a time-limited statute specifically prohibiting assisted suicide; two of those three were appeals of dismissed indictments naming Dr. Jack Kevorkian, and the third was a declaratory judgment challenge to the statute on both state and federal grounds.

Michigan, unlike most states, did not have a statute specifically prohibiting assisted suicide until late 1992. The Michigan Legislature passed legislation[2] including such a prohibition and establishing a commission to study the issue. The statute, including the specific prohibition, expired six months after the commission issued its recommendations. All three cases challenging this statute included an argument that the statute violated the Michigan Constitution because it included multiple subjects. The Michigan Supreme Court rejected this argument. 447 Mich. at 463.

The Michigan Supreme Court also considered—and rejected—the same arguments advanced in the instant case, that such a statute violates the Due Process and Equal Protection Clauses:

> "We conclude [that] the United States Constitution does not prohibit a state from imposing criminal penalties on one who assists another in committing suicide."

447 Mich. at 446.

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[2] 1992 Mich Pub. Acts 270, adopted December 15, 1992, effective March 31, 1993, codified as Mich. Comp. Laws § 752.1027. The law was subsequently amended to become effective February 25, 1993. 1993 Mich. Pub. Acts 3. *See People v. Kevorkian*, 447 Mich. 436, 450-53, 527 N.W.2d 714 (1994), *cert. denied* 115 S. Ct. 1795 (1995).

The fourth case resolved by the Michigan Supreme Court opinion in *Kevorkian* was an appeal from a murder indictment involving conduct that occurred before the specific assisted suicide statute had become effective. The defendant—again Dr. Kevorkian—had been charged with murder under the authority of *People v. Roberts*, 211 Mich. 187, 178 N.W. 690 (1920), which held that assisting a suicide could be charged as a form of murder. The issue in this fourth case was whether assisting a suicide was a crime even without a specific statute.

The Michigan Supreme Court, noting the evolution of the "interpretation of causation in criminal cases" (447 Mich. at 493), overruled *People v. Roberts* "to the extent that it can be read to support the view that the common-law definition of murder encompasses the act of intentionally providing the means by which a person commits suicide". 447 Mich at 494.

However, the Michigan Court also held that assisted suicide continued to be a crime in Michigan:

> "[E]ven absent a statute that specifically proscribes assisted suicide, prosecution and punishment for assisting in a suicide would not be precluded. Rather, such conduct may be prosecuted as a separate common-law offense under [Michigan's common law] saving[s] clause of [Mich. Comp. Laws] § 750.505".

447 Mich. at 495.[3]

Any fair reading of the *Kevorkian* opinion makes it clear that the Michigan Supreme Court concluded that (1) Michigan has a law remaining in effect imposing criminal penalties for assisting a suicide and (2) such laws do not violate the Fourteenth Amendment.[4] This latter conclusion is directly in conflict with the decision below. Plaintiffs' argument that the conflict has somehow "evaporated" because assisting a suicide is today punishable under a different statute is, at best, sophistry.

Plaintiffs also attempt to distinguish the Michigan cases because their central actor—Dr. Jack Kevorkian—has

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[3] Mich. Comp. Laws § 750.505 reads as follows:

> "Any person who shall commit any indictable offense at the common law, for the punishment of which no provision is expressly made by any statute of this state, shall be guilty of a felony, punishable by imprisonment in the state prison not more than 5 years or by a fine of not more than $10,000.00, or both in the discretion of the court."

[4] Any doubts that these two conclusions remain the law in Michigan dissolve in light of the *Kevorkian* Court's observation that

> "[w]hen a court of last resort intentionally takes up, discusses, and decides a question germane to, though not necessarily decisive of, the controversy, such decision is not a dictum but it is a judicial act of the Court which it will thereafter recognize as a binding decision."

444 Mich. at 487 n.65 (quotations and citations omitted). The Michigan Supreme Court's rejection of a constitutional right to assisted suicide was clearly "germane" to its decision that assisted suicide is punishable as a common law crime. Thus, under this principle, the Court's holding in *Kevorkian* continues to be the law in Michigan, and the conflict with the decision below remains.

not limited his "assistance in the deaths of patients . . . either to mentally competent or to terminally ill patients, much less patients who are both mentally competent and terminally ill". Opp'n at 8.[5]

This argument ignores the fact that the *legal* arguments advanced by Dr. Kevorkian and his supporters to the Michigan Supreme Court—and rejected by that Court—were essentially the same as those advanced by Plaintiffs to the courts below. Indeed, the Court explicitly rejected the reasoning of the District Court ruling that was upheld by the Ninth Circuit limited *en banc* panel. *See generally* 447 Mich. at 469-81.

Moreover, a finding of a constitutional right to assisted suicide arguably cloaks at least some of Dr. Kevorkian's actions with the mantle of constitutional protection. His apparent unwillingness to limit his activities to mentally competent, terminally ill individuals demonstrates the difficulty—if not the impossibility—of limiting the new constitutional right created by the Court below to such individuals as well. If anything, Dr. Kevorkian's activities illustrate in very real terms the need for this Court to determine whether a State's ability to regulate such activities is limited by the Constitution.

C. Conflicts With Other Courts

Plaintiffs do not deny that the Ninth Circuit's explicit holding also conflicts with at least one other state court decision, or that its implicit holding diverges from

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[5] It is not clear that Dr. Kevorkian would agree with Plaintiffs' characterization. He recently filed a petition with this Court seeking a writ of certiorari in which he argues, *inter alia*, that "the Due Process Clause encompass[es] the right of a mentally competent, suffering adult to hasten their [sic] own death". Petition for Writ of Certiorari, *Kevorkian v. Michigan*, Case No. 96-135, p. 6.

that of almost every other court that has considered the issue. *See* Petition at 21 n.84, 25-26.

Rather, they contend that the cases cited in the petition are either distinguishable or not "worthy of this Court's attention". Opp'n at 7-8 n.7. Contrary to Plaintiffs' contention, these cases demonstrate just how far from the mainstream of judicial thought the decision below has strayed. The Ninth Circuit is not merely the first court to rule as it did—it is the only appellate court, federal or state, to do so.

Even the Ninth Circuit acknowledged that its decision was a "step beyond what the courts have previously approved". Pet. App. A-8. This Court should accept review to determine whether the Ninth Circuit has indeed gone a step too far.

II. THE TIME FOR THIS COURT TO DETERMINE WHETHER THERE IS A CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE IS NOW

Plaintiffs argue that this Court should decline certiorari "until more state supreme courts and federal circuits have experimented with substantive and procedural solutions to the problem". Opp'n at 9 (quotations and citations omitted). They acknowledge that denial of review "would suggest no expression of the merits" of the decision below. Opp'n at 10 n.8. It would simply leave the question open for resolution on another day.

However, as demonstrated in the Petition, this case presents important issues of public policy potentially affecting every person and issues of federalism certainly affecting every state legislature. These issues cry out for a definitive resolution, a resolution only this Court can give.

Plaintiffs have previously acknowledged the significance of this case. After the panel decision rejected their arguments (*Compassion in Dying* I, Pet. App. D), Plaintiffs argued that the issues in this case "are of exceptional importance [raising] significant federal questions of first impression that are likely to reoccur". Pet. for Reh'g, Suggestions for Reh'g *En Banc* at 9. The issues are no less important, and no less in need of resolution, because Plaintiffs happen to have prevailed in the latest round.

The Court below, with uncharacteristic understatement, recognized that its decision "leaves unresolved a large number of . . . troublesome issues that will require resolution in the years ahead". Pet. App. A-116.

The questions left open by the decision below include at least these:

- The definition of terminal illness for purposes of exercising this newly created right;
- Whether the newly created right is or can be limited to the terminally ill;
- The procedural limitations, if any, a State may establish to determine whether an individual is in fact terminally ill;
- Whether the newly created right is or can be limited to the mentally competent;
- The standard for determining mental competence for the purpose of exercising this new right;

- The procedural limitations, if any, a State may establish to determine whether an individual is in fact mentally competent;
- The procedural limitations, if any, a State may establish to determine that an individual's decision to commit suicide is in fact voluntary;
- Whether the newly created right is limited to physician prescription of medications or may also include a right to physician administration of medications or to assistance involving neither physicians nor medications.

Were Plaintiffs' approach adopted, the next several years would see a vast expenditure of legislative and judicial energies devoted to answering these and related questions. Then, at some future point, this Court would decide whether the alleged right really exists and whether all this activity was necessary in the first place. Plaintiffs' suggestion that such an approach serves "[s]ound principles of judicial restraint" can most charitably be described as disingenuous.

Petitioners agree that it would have been best not to inject the judiciary into the hotly debated policy question of whether some form of physician assisted suicide should be allowed. However, Plaintiffs' decision to move the debate to the courtroom, coupled with the Ninth Circuit's willingness to become the central decision-maker, require this Court to likewise become involved, at least to determine whether this hotly debated social policy question has but one constitutionally compelled answer.

III. CONCLUSION

For these reasons, and the reasons set forth in the Petition for Writ of Certiorari and amicus briefs in support thereof, this Court should grant the Petition for Writ of Certiorari and reverse the decision of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted this 28th day of August, 1996.

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IN THE

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

SUPPLEMENTAL BRIEF OF RESPONDENTS IN RESPONSE TO BRIEF AMICI CURIAE OF SEVERAL STATES

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Pursuant to Supreme Court Rule 15.7, Respondents submit this supplemental brief in response to the brief submitted by several states as amici curiae. *Brief of Amici Curiae States of California, et al.*[1]

I. THE AMICUS BRIEF FAILS TO MEET THE STANDARD FOR AN AMICUS SUBMITTAL

The amicus brief fails to meet the standard set forth in Supreme Court Rule 37.1, which requires that amicus briefs bring to the attention of the Court relevant matter that has not already been brought to its attention by the parties. Petitioners have already addressed at length the issues briefed by these amici. Respondents have addressed each argument in their opposition brief and will not restate these arguments here, but will simply respond to two points raised by amici.

II. AMICI'S FEDERALISM ARGUMENT IS MISGUIDED

Amici contend that the decision below offends principles of federalism. Amici Br. at 17. This argument is misguided. Where constitutional rights are infringed by state legislative action, it is the duty of the judiciary to intervene and protect such rights.[2] *See, e.g., Schweiker v. Wilson*, 450 U.S. 221, 230 (1981) (where the democratic process impinges on constitutional rights, "the judiciary then has a duty to intervene in the democratic process"); *Marshall Field & Co. v.*

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[1] The amicus brief presents the views of less than one-third of the states. The vast majority of states do not urge that review be granted.

[2] A recent, cogent refutation of the flawed federalism argument advanced by the states is set forth in R. Dworkin's *Freedom's Law* (Harvard University Press 1996).

Clark, 143 U.S. 649, 670 (1892) (recognizing "duty of this court, from the performance of which it may not shrink, to give full effect to the provisions of the Constitution"); *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

Moreover, rather than usurping the states' role, the decision below respects the proper role of the state in regulating physician assisted dying. The Second Circuit's analysis relies on basic equal protection principles in ruling that New York, having passed legislation permitting physician assisted death in a variety of circumstances, cannot deny physician assistance in the narrow circumstances presented here. That is, having granted the right to medically assisted death to its dying citizens, New York cannot constitutionally deny some dying citizens an equivalent exercise of that right.

States that have granted and continue to grant the right to physician assistance in dying are free to, and indeed should, develop regulatory schemes addressing physician assisted death. Current state laws pertaining to living wills and health proxies begin to do just that. Far from ignoring states' autonomy in this area, the decision below explicitly acknowledges that states will continue to play an important role in regulating physician assisted dying. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).

States cannot reasonably claim ignorance with regard to what further regulatory schemes might be appropriate. Proposed schemes abound in both legal and medical literature. *E.g.*, Charles Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harvard J. on Legis. 1 (Winter 1996); Timothy E. Quill, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 N. Eng. J. Med. 1380 (1992); N.Y. A.B. 6333, 219th Leg., 2d Sess. (1995).

III. STATE POLICE POWER DOES NOT TRUMP THE EQUAL PROTECTION CLAUSE

Contrary to amici's argument, the police power of states does not trump states' obligation to remain within the bounds of the Equal Protection Clause. Here, the police power does not extend to disallowing a dignified death to an arbitrary subgroup of dying citizens.

Historically, in every case in which a state has sought to constrain equal rights and liberties of individuals, the state has defended its action as within its police power. This was true where individuals sought desegregation of schools, *Brown v. Board of Education*, 347 U.S. 483 (1954), where individuals desired access to contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965), where individuals of different races sought to marry, *Loving v. Virginia*, 385 U.S. 986 (1966), where women sought access to abortion services, *Roe v. Wade*, 410 U.S. 113 (1973), and where families sought to arrange the composition of their homes, *Moore v. City of East Cleveland*, 431 U.S. 494 (1977). The state's argument in support of its power to act in the context of this case is far weaker than in many of the cases where this Court has determined that the police power is not as expansive as the state urged. As the Court below recognized, the proper scope of state action is limited to reasonable regulation designed to protect legitimate state interests.

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In The

Supreme Court of the United States

October Term, 1995

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF AMICI CURIAE STATES OF CALIFORNIA, ALABAMA, COLORADO, FLORIDA, GEORGIA, IOWA, MARYLAND, MICHIGAN, MONTANA, NEBRASKA, NEW HAMPSHIRE, NEW YORK, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, VIRGINIA AND COMMONWEALTH OF PUERTO RICO AND TERRITORY OF AMERICAN SAMOA IN SUPPORT OF PETITIONERS STATE OF WASHINGTON, ET AL.

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QUESTIONS PRESENTED FOR REVIEW

Whether there is a liberty interest under the Due Process Clause of the Fourteenth Amendment to commit suicide and, if so, whether it includes an interest to receive the assistance of another to do so?

Whether, balancing asserted interests in suicide and assisted suicide against relevant state interests, respondent's constitutional rights are violated by Washington's absolute prohibition of assisted suicide?

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I. INTEREST OF THE AMICI CURIAE

For over two centuries, federalism has stood as the cornerstone of our republican form of government. Indeed, as this Court has declared, "the preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National Government. The Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States." *Texas v. White*, 74 U.S. (7 Wall.) 799, 725 (1869). Respect for state sovereignty and the power of the people to directly govern their own affairs, unless excluded by the Constitution or valid Act of Congress, is the embodiment of our federalism.[1] It is this understanding of federalism which ensured ratification of the Constitution and, until the case below, safeguarded the essential role of the States in our federal system.

In the history of our Nation, no court of final jurisdiction has ever declared the existence of a constitutional right or interest to commit suicide or assisted suicide.[2] However, in a radical departure from our Nation's history and tradition, and contrary to the laws of a majority of States, the Ninth Circuit has announced its discovery of new rights to commit suicide and assisted suicide imbedded in the Due Process Clause of the Fourteenth Amendment.[3] The Ninth Circuit's holding

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[1] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people." U.S. Const. amend. X.

[2] The Second Circuit has rejected the claim that there is a liberty interest in assisted suicide under the Due Process Clause of the Fourteenth Amendment. *Quill v. Vacco*, 80 F.3d 716, 723-725 (2d Cir. 1996) (hereinafter "*Quill*"). The Second Circuit did, however, invalidate New York's prohibition of assisted suicide on equal protection grounds. *Quill*, 80 F.3d at 725-731. On May 16, 1996, a petition for certiorari was filed by Dennis C. Vacco, Attorney General of the State of New York, *et al.*, seeking review of the Second Circuit's opinion in the *Quill* case.

[3] *Compassion in Dying v. State of Washington*, 79 F.3d 790, 793-794 (9th Cir. 1996) (*en banc*) (hereinafter "*Compassion in Dying II*"). A limited eleven-judge *en banc* panel vacated the previous decision of the three-

strikes at the very heart of this Court's federalism jurisprudence and, upon review, falls far short of overcoming the "great resistance" to expansion of the substantive content of the Due Process Clause.[4] *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986). The Ninth Circuit's opinion also "calls for some judgment about the limits of the [Judiciary's] role in carrying out its constitutional mandate." *Bowers*, 478 U.S. at 190.

If allowed to stand, the Ninth Circuit's opinion will precipitate a fundamental change in the long-standing policies of a majority of States to prevent suicide and assisted suicide. "[A]ll states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) (footnotes omitted), *cert. denied*, 115 S.Ct. 1795 (1995). A majority of States impose criminal penalties on those who assist another to commit suicide.

At stake in this case are, first and foremost, the lives of the people, both those who wish to die and those who wish to live no matter what their circumstances. Also at stake is the sovereign power of the States to protect and preserve those lives *without* a federal requirement that the State "make judgments about the 'quality' of life that a particular individual may enjoy, . . . " *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 (1990). The resolution of this

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judge panel, reported at *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995) (hereinafter "*Compassion in Dying I*"), which had voted 2-1 to reverse the district court decision, reported at 850 F.Supp. 1454 (W.D. Wash. 1994). Thereafter, an active judge *sua sponte* requested that the full court *en banc* rehear the case, however, that request failed to receive a majority of the votes of the non-recused active judges and was rejected. Dissenting opinions from the order rejecting the request for rehearing were filed by Circuit Judges O'Scannlain and Trott. *Compassion in Dying v. State of Washington*, 85 F.3d 1440 (9th Cir. 1996).

[4] Unless otherwise noted, the term "Due Process Clause" as used herein refers to the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

question will arguably affect more lives than any case which this Court will confront in the foreseeable future. It will also determine whether "the States *as States* have [any] legitimate interests which the National Government is bound to respect even though its laws are supreme." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 581 (1985) (O'Connor, J., dissenting) (italics original, citation omitted, insert added).

II. REASONS FOR GRANTING THE WRIT

Perhaps the best evidence of the extent of the Ninth Circuit's departure from our Nation's historical and traditional treatment of suicide and assisted suicide is the number of conflicts created by the decision. In *Compassion in Dying II*, the Ninth Circuit announced its discovery of a new "constitutionally-protected liberty interest in determining the time and manner of one's own death . . . " *Compassion in Dying II*, 79 F.3d at 793. That decision is in direct conflict with the Second Circuit's recent holding in *Quill v. Vacco* that:

> "The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death. We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow." *Quill*, 80 F.3d at 724-725.

The Ninth Circuit's opinion also squarely conflicts with the recent decision of the Michigan Supreme Court in *People v. Kevorkian* where, on the identical substantive due process issue, the Court held that:

> "On the basis of the foregoing analysis, we would hold that the right to commit suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this nation's history and tradition. It would be an impermissibly radical departure from existing tradition, and from the principles that underlie that tradition, to declare that there is such a

fundamental right protected by the Due Process Clause."[5]

Like its holding, the rationale utilized by the Ninth Circuit also creates numerous conflicts. In *Compassion in Dying II*, the Ninth Circuit found no difference between the withdrawal of life support, on the one hand, and the act of suicide, on the other. *Compassion in Dying II*, 79 F.3d at 821-824. However, "those courts that have found a right to refuse to begin or to continue life-sustaining medical treatment have done so only after concluding that such refusal is wholly different from the act of suicide."[6] Numerous state legislatures have likewise recognized this fundamental distinction.[7]

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[5] *People v. Kevorkian*, 447 Mich. 436, 481, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995). The Ninth Circuit's opinion also conflicts with the holding of the California Court of Appeals in *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1619-1623, 4 Cal.Rptr.2d 59, 61-64 (1992), wherein the court considered whether a terminally ill individual's constitutional rights to privacy and to refuse medical treatment under the United States and California Constitutions included a right to an assisted suicide. After balancing Donaldson's interests against those of the State, the court concluded that he had "no constitutional right to a state-assisted death." *Donaldson*, 2 Cal.App.4th at 1623. While the court in *Donaldson* considered whether a right to an assisted suicide was encompassed by a generalized constitutional right of privacy, like the issue in *Cruzan*, "this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 n.7 (1990).

[6] *People v. Kevorkian*, 447 Mich. 436, 480, 527 N.W.2d 714, 732 (1994) (footnote omitted), *cert. denied*, 115 S.Ct. 1795 (1995). *See, e.g., Von Holden v. Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 627 (1982) ("essential dissimilarity" between right to decline medical treatment and any right to end one's life); *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 1145, 225 Cal.Rptr. 297, 306 (1986); *Bartling v. Superior Court*, 163 Cal.App.3d 186, 196, 209 Cal.Rptr. 220, 225-226 (1984); *People v. Adams*, 216 Cal.App.3d 1431, 1440, 265 Cal.Rptr. 568, 573-574 (1990); *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1619-1623, 4 Cal.Rptr.2d 59, 61-64 (1992) and cases cited therein; *Thor v. Superior Court*, 5 Cal.4th 725, 742, 21 Cal.Rptr.2d 357, 367-368 (1993); *DeGrella v. Elston*, 858 S.W.2d 698, 706-707 (Ky. 1993). *Cf. In re Quinlan*, 70 N.J. 10, 51-52 and n.9, 355 A.2d 647, 669-670 and n.9 (neither attempted nor aiding suicide implicated in circumstances similar to those presented), *cert. denied*, 429 U.S. 922 (1976). *See also* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 10 n.34 (1985), and cases cited therein.

Finally, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), this Court "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition" but, at the same time, recognized Missouri's important interest in the protection and preservation of human life, noting that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 279-280 (footnote omitted, insert added). As Circuit Judge Noonan, writing for the majority in *Compassion in Dying I*, astutely observed, "[w]hatever difficulty the district court [and, likewise, the *en banc* panel] experienced in distinguishing one situation from the other, it was not experienced by the majority in *Cruzan*." *Compassion in Dying I*, 49 F.3d 586, 591 (9th Cir. 1995) (insert added), *superseded by* 79 F.3d 790 (9th Cir. 1996). These conflicts, involving an issue of such exceptional and profound nationwide importance, can only be resolved – indeed, must be resolved – by the final authoritative voice of this Court.

A. Certiorari Should be Granted to Establish That There is No Liberty Interest Under The Due Process Clause of the Fourteenth Amendment To Commit Suicide or To Receive The Assistance of Another To Do So

The issue presented in this case is whether there is a liberty interest under the Due Process Clause of the Fourteenth Amendment to commit suicide and, if so, whether it includes an interest to receive the assistance of another to do

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[7] *See* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, 799, 806 n.25 (1994) ("legislatures that have codified the right to refuse treatment in the same legislation reject any affirmative act to end life."), *citing* natural death/living will statutes of forty States.

so. Resolution of this issue, like all substantive due process adjudication, must begin with the cautionary note expressed by this Court in *Bowers v. Hardwick*, 478 U.S. 186 (1986):

> "Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority. . . . " *Bowers*, 478 U.S. at 194-195.

This Court recently reaffirmed that "great resistance" in *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992), declaring that "[a]s a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended. [citation omitted]" Mindful of that "great resistance", it is of critical importance that lower courts carefully adhere to the principles established by this Court when construing the substantive content of the Due Process Clause. Unfortunately, the Ninth Circuit failed in this regard. Certiorari should be granted to overrule *Compassion in Dying II* and, equally important, to reaffirm those principles, established by this Court, which govern substantive due process adjudication.

1. The Constitutional Analysis Utilized by the Ninth Circuit in *Compassion in Dying II* was Fundamentally Flawed

In the perilous waters of substantive due process adjudication, a carefully focused approach helps to eliminate the irrelevant, illuminate the pertinent, and insure that the discovery of new rights is "much more than the imposition of the Justices' own choice of values on the States and Federal Government, . . . ". *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986). Indeed, this Court has made clear that " '[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field." *Reno v. Flores*, 507 U.S. 292, 302 (1993) (further citation omitted). Thus, in *Bowers v. Hardwick*, 478 U.S. 186 (1986), this Court carefully focused on the specific conduct at issue when it framed the question presented as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy . . . " *Bowers*, 478 U.S. at 190. The focus of the Court's inquiry was not whether one has a right to engage in sexual conduct of one's choice but, rather, whether the specific conduct at issue, *i.e.*, homosexual sodomy, was entitled to constitutional protection. Likewise, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), this Court carefully focused on whether Nancy Cruzan had "a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under [her] circumstances." *Cruzan*, 497 U.S. at 269 (insert added). This carefully focused approach allowed the Court to first identify the specific conduct at issue (*i.e.*, the withdrawal or withholding of unwanted medical treatment), and then the relevant historical traditions (*i.e.*, the doctrines of informed consent and bodily integrity) protecting or denying protection to that conduct. *Cf. Michael H. v. Gerald D.*, 491 U.S. 110, 127-128 n.6 (1989) (Scalia, J.).

Rather than carefully focusing on suicide and assisted suicide, the Ninth Circuit broadly framed the question presented as "whether there is a liberty interest in determining

the time and manner of one's death." *Compassion in Dying II*, 79 F.3d at 800. By doing so, it opened the door to consideration of a host of activities which are wholly dissimilar from suicide and which plainly involve different considerations. Indeed, even the Ninth Circuit acknowledged that "[t]he liberty interest we examine encompasses a whole range of acts that are generally not considered to constitute 'suicide.'" *Compassion in Dying II*, 79 F.3d at 802.

In sharp contrast to the Ninth Circuit's broad approach, other courts which have considered this identical question have utilized a carefully focused approach consistent with the precedents of this Court.[8] The Ninth Circuit's rationale for broadly framing the question presented was its belief that "it is the end and not the means that defines the liberty interest." *Compassion in Dying II*, 79 F.3d at 801. If true, however, the issues framed by this Court in both *Bowers* and *Cruzan* were far too narrow. Rather, under the Ninth Circuit's new "end-result" standard for defining liberty interests, the issue in *Bowers* should have been whether there is a "liberty interest in sexual pleasure" and, in *Cruzan*, whether there is a "liberty interest to determine the time and manner of one's death." Entirely inconsistent with the precedents of this Court, the Ninth Circuit's new "end-result" standard is also inimical to the principles of federalism which underlie that "great resistance" to expansion of the substantive content of the Due Process Clause.

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[8] *See, e.g., Quill*, 80 F.3d at 723 (Second Circuit carefully focusing on plaintiffs' argument "for a right to assisted suicide as a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment.") and *People v. Kevorkian*, 447 Mich. 436, 464, 527 N.W.2d 714, 724 (1994) (Michigan Supreme Court carefully focusing its inquiry on "whether the [Due Process Clause] encompasses a fundamental right to commit suicide and, if so, whether it includes a right to assistance."), *cert. denied*, 115 S.Ct. 1795 (1995).

2. The Due Process Clause of the Fourteenth Amendment Does Not Encompass A Liberty Interest To Commit Suicide Or To Receive the Assistance of Another to Do So

The Due Process Clause of the Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law; . . . " U.S. Const. amend. XIV, § 1. Nowhere in the plain language of the Clause is an interest in committing suicide or assisted suicide expressly granted. Nor does the *design* of the Clause support any such contention.[9] The design of the Clause establishes life as the first interest to be accorded substantive and procedural protection, liberty the second, and property the third. The reason for this design is manifest: without life, liberty cannot exist and property cannot be acquired. Any finding of a "liberty interest" to extinguish the life of a "person" inverts the order and is directly contradicted by, and inconsistent with, the design of the Clause itself.[10] Unsupported by the plain language of the Clause and antithetical to its design, there must necessarily be a strong presumption against the contention that such an interest can nevertheless be implied in the substantive content of the Clause itself.[11]

This Court has established the principles to be used by the Judiciary when identifying "rights that have little or no textual

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[9] "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language *or design* of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986) (emphasis added).

[10] *See* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, (1994) at p. 807. Of course, this conflict was not presented in the abortion context since, under *Roe*, "the word 'person,' as used in the Fourteenth Amendment does not include the unborn. [footnote omitted]." *Roe v. Wade*, 410 U.S. 113, 158 (1973).

[11] Individual interests are not afforded any less protection simply because the government, rather than the individual, is defending them. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 n.10 (1990).

support in the constitutional language." *Bowers*, 478 U.S. at 191 (further citation omitted).

> "In *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937), it was said that this category includes those fundamental liberties that are 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [they] were sacrificed.' A different description of fundamental liberties appeared in *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion by Powell, J.), where they are characterized as those liberties that are 'deeply rooted in this Nation's history and tradition.' [citations omitted]" *Bowers*, 478 U.S. at 191-192.

In approaching an historical analysis to determine whether a particular practice has been accepted by our people, it is important to remember that it is *this* Nation's history and tradition which is dispositive. *Cf. Bowers*, 478 U.S. at 191-194. An analysis, such as that engaged in by the Ninth Circuit in *Compassion in Dying II*, which centers primarily on "ancient attitudes" having little, if any, relevance to America's historical and traditional treatment of suicide and assisted suicide cannot establish that such practices have been accepted by our Nation. *Cf. Stanford v. Kentucky*, 492 U.S. 361, 369 n.1 (1989).

Opposition to suicide is deeply rooted in *this* Nation's history and tradition. "At common law suicide was a felony, punished by forfeiture of property to the king and ignominious burial. Essentially, suicide was considered a form of murder." *In re Joseph G.*, 34 Cal.3d 429, 433, 194 Cal.Rptr. 163, 165 (1983) (citations omitted). While no State has a statute imposing criminal penalties for a successful suicide,

> "abolition of such 'punishments' as ignominious burial for suicide and then the decriminalization of both suicide and attempted suicide did not come about because suicide was deemed a 'human right' or even because it was no longer considered reprehensible. These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those

> who committed or attempted to commit the act were thought to be prompted by mental illness."[12]

In the United States, suicide continues " 'to be considered an expression of mental illness.' "[13] Indeed, the New York State Task Force on Life and the Law found that "[s]tudies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death."[14] "[A]ll states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) (footnotes omitted), *cert. denied*, 115 S.Ct. 1795 (1995). Simply stated, as Justice Scalia pointed out in his concurring opinion in *Cruzan*, " 'there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.' "[15]

Logically, if there is no liberty interest to commit suicide, there can be no liberty interest in receiving the assistance of another to do so. *People v. Kevorkian*, 447 Mich. 436, 468 n.35, 527 N.W.2d 714, 726 n.35 (1994), *cert. denied*, 115 S.Ct. 1795 (1995). However, an independent analysis of the issue provides even more evidence that no such derivative interest exists. At

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[12] Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Report, No. 3, 32 (1993) (footnote omitted). See also *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 294-295 (1990) (Scalia, J., concurring).

[13] *In re Joseph G.*, 34 Cal.3d 429, 433, 194 Cal.Rptr. 163, 165 (1983) (citation omitted). *See also, Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1624, 4 Cal.Rptr.2d 59, 64 (1992).

[14] New York State Task Force Report, *When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context* (hereinafter "*New York State Task Force Report*") (May 1994) at 11.

[15] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 295 (1990) (Scalia, J., concurring) (citation omitted). *See also* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 100 (1985) (reaching identical conclusion); and *New York State Task Force Report*, at 54-54 and 67-75.

common law, a person who assisted another to commit suicide was guilty of murder. *In re Joseph G.*, 34 Cal.3d 429, 434, 194 Cal.Rptr. 163, 165 (1983).

> "At the time the Fourteenth Amendment was ratified, at least twenty-one of the thirty-seven existing states (including eighteen of the thirty ratifying states) proscribed assisted suicide either by statute or as a common-law offense." *People v. Kevorkian*, 447 Mich. 436, 478, 527 N.W.2d 714, 731 (1994) (citation omitted), *cert. denied*, 115 S.Ct. 1795 (1995).

Today, while a few states continue to classify assisted suicide as murder or manslaughter, "the predominant statutory scheme is to create a sui generis crime of aiding and abetting suicide." *In re Joseph G.*, 34 Cal.3d 429, 434, 194 Cal.Rptr. 163, 165 (1983). At least forty States, Puerto Rico and the Virgin Islands, impose criminal penalties on those who assist another to commit suicide.[16]

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[16] The following states and territories have statutes which impose criminal penalties for aiding, assisting, causing, or promoting suicide: Alaska Stat., § 11.41.120(a)(2); Ariz. Rev. Stat. Ann., § 13-1103(A)(3); Ark. Stat. Ann., § 5-10-104(a)(2); Cal. Pen. Code, § 401; Colo. Rev. Stat., § 18-3-104(1)(b); Conn. Gen. Stat., § 53a-56(a)(2); Del. Code Ann., tit. 11, § 645; Fla. Stat. Ann., § 782.08; Ga. Code Ann. § 16-5-5(b); Ill. Comp. Stat. ch. 720, 5/12-31; Ind. Stat. Ann., § 35-42-1-2.5(b); Iowa Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann., § 21-3406; Ky. Rev. Stat., § 216:302; La. Rev. Stat., § 14:32.12; Me. Rev. Stat. Ann., tit. 17-A, § 204; Minn. Stat. Ann., § 609.215; Miss. Code Ann., § 97-3-49; Mo. Ann. Stat., § 565.023(1)(2); Mont. Code Ann., § 45-5-105; Neb. Rev. Stat., § 28-307; N.H. Rev. Stat. Ann., § 630:4; N.J. Stat. Ann., § 2C:11-6; N.M. Stat. Ann., § 30-2-4; N.Y. Penal Law, §§ 120.30, 125.15(3); N.D. Cent. Code, § 12.1-16-04; Okla. Stat. Ann., tit. 21, §§ 813-818; 18 Pa. Cons. Stat. Ann., § 2505; P.R. Laws Ann., tit. 33, § 4009; S.D. Codified Laws Ann., § 22-16-37; Tenn. Code Ann., § 39-13-216; Tex. Penal Code Ann., § 22.08; V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060; and Wis. Stat. Ann., § 940.12. The following states have statutes which impose criminal penalties for negligent homicide which are broad enough to encompass aiding, assisting, causing or promoting suicide: Ala. Code, § 13A-6-1; and Wyo. Stat., § 6-2-107. The following states impose criminal penalties by case law for assisting a suicide: *Commonwealth v. Mink*, 123 Mass. 422, 428-429 (1877); *People v. Kevorkian*, 447 Mich. 436, 493-497, 527 N.W.2d 714, 738-739 (1994), *cert. denied*, 115 S.Ct. 1795 (1995); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); *State v. Jones*, 86 S.C. 17, 22, 47, 67 S.E. 160, 162, 165 (1910); and *State v. Willis*, 255 N.C. 473, 477, 121 S.E.2d 854, 856-857 (1961).

Against this background, the contention that assisted suicide is "deeply rooted in this Nation's history and tradition" or "implicit in the concept of ordered liberty" is entirely devoid of merit. *Cf. Bowers v. Hardwick*, 478 U.S. 186, 192-194 (1986).

3. The Ninth Circuit's Reliance on *Casey* and *Cruzan* in Declaring the Existence of New Liberty Interests in Suicide and Assisted Suicide Was Entirely Misplaced

Neither *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), nor *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), support the Ninth Circuit's discovery of new liberty interests to commit suicide and assisted suicide. In *Casey*, the Court was not called upon to decide whether some newly asserted liberty interest to choose an abortion was entitled to constitutional protection. Rather, the primary question presented was whether the fundamental holding of *Roe v. Wade*, 410 U.S. 113 (1973), should be overruled. *Casey*, 505 U.S. at 844-846. Thus, the Court had no reason to discuss, and did not discuss, the well-established principles for construing the substantive content of the Due Process Clause.

Notwithstanding this fact, the Ninth Circuit found *Casey* to be "highly instructive and almost prescriptive for determining what liberty interest may inhere in a terminally ill person's choice to commit suicide." *Compassion in Dying II*, 79 F.3d at 813 (citation and internal quotes omitted). This was error. Contrary to the Ninth Circuit's reasoning, the three sentences in *Casey* it relied upon – broad generalities on the nature of the liberty protected by the Fourteenth Amendment – did not establish a new standard for construing the substantive content of the Due Process Clause. *Compassion in Dying II*, 79 F.3d at 813, *quoting Casey*, 505 U.S. at 851. Moreover, if allowed to stand, the Ninth Circuit's interpretation of these three sentences would virtually eliminate the "guideposts for responsible decisionmaking in this unchartered

area" (*Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992)) since many activities which are plainly not entitled to constitutional protection can nevertheless be characterized as "intimate", "personal" or involving "choices central to personal dignity and autonomy".

The Ninth Circuit's reliance on *Casey* was also predicated on the mistaken notion that simply because a decision may involve "choices central to personal dignity and autonomy", one is free to do whatever one wants with one's body. However, this is precisely the sort of "unlimited right to do with one's body as one pleases" which this Court has consistently and soundly rejected. *See Roe v. Wade*, 410 U.S. 113, 154 (1973); *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); and *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 (1973), *citing*, *inter alia*, constitutionally unchallenged laws against suicide. The Ninth Circuit's reliance on *Casey* also ignores the fundamental differences between abortion and suicide. This Court has held that abortion does not extinguish the life of a "person" in the context of the Fourteenth Amendment.[17] Certainly, it cannot be denied that suicide does. Under *Roe*, abortion concerns the choice of a woman, the decision-maker, to live her life without the dangers and unwanted conditions associated with pregnancy.[18] Suicide, on the other hand, is about death, *i.e.*, the death of the decision-maker. As Justice O'Connor observed in her opinion in *Casey*, "[a]bortion is a unique act" and "the liberty interest of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. It is error to seek to discover new constitutional rights to commit suicide and assisted suicide by analogizing to the unique abortion rights jurisprudence. There is no indication in *Casey*, or the precedent from which it

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[17] *Roe v. Wade*, 410 U.S. 113, 158 (1973) ("the word 'person,' as used in the Fourteenth Amendment, does not include the unborn. [footnote omitted]"). While not a "person", it is of course well-settled that States have "legitimate interests from the outset of the pregnancy in protecting . . . the life of the fetus that may become a child." *Casey*, 505 U.S. at 846.

[18] *Roe v. Wade*, 410 U.S. 113, 153 (1973) (listing factors a woman and her physician would necessarily consider when considering an abortion).

evolved, of an intention to expand the liberty interests previously identified by this Court in the manner utilized by the Ninth Circuit.

Nor does this Court's decision in *Cruzan* support the Ninth Circuit's discovery of new liberty interests to commit suicide and assisted suicide. In *Cruzan*, this Court observed that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, 497 U.S. at 278. Later in the opinion, the Court stated that "*for purposes of this case*, we *assume* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Cruzan*, 497 U.S. at 279 (emphasis added). Careful examination of this portion of the *Cruzan* opinion reveals two critical points. First, the Court *assumed*, but did not expressly hold, that there is a constitutionally protected interest to refuse life-sustaining medical treatment. Second, this assumption was expressly limited to the *Cruzan* case. Notwithstanding this clear language, the Ninth Circuit read *Cruzan* as "necessarily recogniz[ing] a liberty interest in hastening one's own death." *Compassion in Dying II*, 79 F.3d at 816 (footnote omitted, insert added). Such a reading of *Cruzan* assumes far too much. It is error to attempt to construe *Cruzan's* limited assumption of an interest to refuse medical treatment as acceptance by this Court of a far broader interest to commit suicide and, broader still, assisted suicide. Indeed, the error of such an attempt is plainly evidenced by the majority's recognition in *Cruzan* that, even in the face of a right to refuse medical treatment, the States may properly assert important interests in the protection and preservation of human life, and in the prevention of both suicide and assisted suicide.[19] *Cruzan*, 497 U.S. at 280-282. In summary, suicide and assisted suicide are so significantly different from the refusal of unwanted medical treatment, and its legal underpinnings, that an interest in

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[19] Unlike suicide, "[t]he right to refuse medical treatment meets the 'ordered liberty' and the 'historical underpinnings' tests because it is rooted in the common-law doctrine of informed consent, which embodies the notion of bodily integrity." *People v. Kevorkian*, 447 Mich. 436, 480 n.59, 527 N.W.2d 714, 732 n.59 (1994), *cert. denied*, 115 S.Ct. 1795 (1995).

committing suicide or assisted suicide simply cannot be inferred from *Cruzan*.

4. Relevant State Interests Clearly Outweigh the Alleged Liberty Interests in Suicide and Assisted Suicide

In order to determine whether Washington's prohibition of assisted suicide violates the Due Process Clause, the asserted interests in suicide and assisted suicide must be balanced against relevant state interests.[20] *Cruzan*, 497 U.S. at 261. The wide range of circumstances within which these newly discovered interests to commit suicide and assisted suicide could be exercised implicate several important state interests, including, but not limited to: (1) the protection and preservation of human life;[21] (2) the prevention of suicide;[22] (3) preventing the fraud, errors and abuse which

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[20] Since respondents have not even attempted to demonstrate that there is no set of circumstances under which Washington's prohibition of assisted suicide would be valid, their facial challenge to the statute must necessarily fail under *United States v. Salerno*, 481 U.S. 739, 745 (1987). The district court characterized respondents' challenge to Washington's statute as "facial". *Compassion in Dying v. State of Washington*, 850 F.Supp. 1454, 1459 (W.D. Wash. 1994). Upon review, a majority of the three-judge panel found the district court's facial invalidation of the statute to be "wholly unwarranted" under both *Salerno* and *Casey*. *Compassion in Dying I*, 49 F.3d 586, 591 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996). However, the *en banc* panel held respondents' challenge to be "as-applied", declaring that "[s]ince the claimed liberty issue in this case is in many respects similar to the liberty issue involved in *Casey*, . . . we believe that the *Salerno* test would not in any event be the appropriate one for adjudicating a facial challenge to Washington's prohibition on assisted suicide." *Compassion in Dying II*, 79 F.3d 790, 798 n.9 (9th Cir. 1996). Certiorari should be granted to decide whether the *Salerno* test applies outside the abortion context to what the amici States maintain is a facial challenge to Washington's statutory prohibition of assisted suicide.

[21] *Cruzan*, 497 U.S. at 280.

[22] "Suicide is the eighth leading cause of death in the United States." *New York State Task Force Report*, at 9 (footnote omitted). "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." *Id.*, at 11. Furthermore, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.*, at 13 (footnote omitted).

would accompany acceptance of suicide and assisted suicide;[23] (4) maintaining the ethical integrity of the medical profession;[24] (5) protecting the poor and minorities from exploitation;[25] (6) protecting handicapped persons from societal indifference;[26] and (7) protecting innocent third parties.[27]

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[23] *Cruzan*, 497 U.S. at 281 ("[E]ven where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations. [citation omitted, internal quotes omitted]"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr. 59, 64 (1992) ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."), and *Donaldson*, 2 Cal.App.4th at 1624 ("Third parties, even family members, do not always act to protect the person whose life will end.").

[24] *Cf. Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 434 (1982) (important state interest in "maintaining and assuring the professional conduct of professional attorneys it licenses"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1620, 4 Cal.Rptr.2d 59, 62 (1992) (recognizing state interest in maintaining the ethical integrity of the medical profession). In reaffirming its long-standing opposition to physician assisted suicide, the American Medical Association has declared that physician-assisted suicide "threatens the very core of the medical profession's ethical integrity" and is "fundamentally inconsistent with the physician's professional role." American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics Reports*, Vol. V, No. 2 (July 1994), Report 59, *Physician-Assisted Suicide*, 269 and 274, respectively.

[25] *Quill*, 80 F.3d at 730, *citing Compassion in Dying I*, 49 F.3d 586, 592 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[26] *Quill*, 80 F.3d at 730, *citing Compassion in Dying I*, 49 F.3d 586, 592-593 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[27] *Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 331 F.2d 1000, 1008 (1964), *cert. denied*, 377 U.S.

While the Ninth Circuit acknowledged, at least to some extent, some of these interests, its application of the balancing test was fundamentally flawed by the improper insertion of quality-of-life considerations which it used to discount the strength of various important state interests.[28] Such quality-of-life considerations are directly contrary to this Court's holding in *Cruzan* that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282.

Moreover, the dangers inherent in using such quality-of-life considerations are well-recognized. "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 422 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). Such an analysis also disregards the irrefutable principle that all lives, from beginning to end and irrespective of physical or mental condition, are under the full protection of the law. *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring), citing *Blackburn v. State*, 23 Ohio St. 146, 163 (1873). Properly weighed, without the insertion of improper quality-of-life considerations, the States' interests, individually and collectively,

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978 (1964). *See also Bartling v. Superior Court*, 163 Cal.App.3d 186, 195 n.6, 209 Cal.Rptr. 220, 225 n.6 (1984).

[28] *Compassion in Dying II*, 79 F.3d at 817 (strength of the state's important interest in the preservation of human life "is dependent on relevant circumstances, including the medical condition and the wishes of the patient whose life is at stake."); *Id.*, at 820 (state interest in preventing suicide, "like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die. [footnote omitted]"); *Id.*, at 825 (state interest in preventing involvement of third persons at a minimum "when the assistance is provided by or under the supervision or direction of a doctor and the recipient is a terminally ill patient."); and *Id.*, at 827 (state interest in protecting innocent third parties "is of almost negligible weight when the patient is terminally ill and his death is imminent and inevitable.").

clearly outweigh any individual interests in committing suicide and assisted suicide.

B. Certiorari Should be Granted to Reaffirm the States' Essential Role in our Federal System of Government and the Power of the People to Directly Govern Their Own Affairs

With the ever-increasing power of medical science to prolong life, even in the face of what would otherwise be terminal illness, the States have had to strike a balance between the rights of the individual and the demands of organized society. That balance is grounded in the States' recognition of their responsibility to protect both individual rights and, at the same time, the lives of those who wish to live-no matter what their circumstances. In striking that balance, the States have drawn a line between an individual's "right to be let alone",[29] on the one hand, and intentionally killing oneself, with or without assistance, on the other. That balance, now a national consensus, is represented by statutes in a majority of states which codify an individual's right to refuse unwanted medical treatment and, in the same legislation, reject any affirmative act to end life. Whether that balance should be abandoned and the line redrawn to permit an individual to commit suicide without state interference, and then redrawn yet again to permit assisted suicide, is a matter appropriately left for the people to decide, through their duly elected representatives or by initiative ballot.[30] The principles of federalism embodied in our Constitution require no less.

As the States continue to grapple with the difficult questions presented by the ever-increasing ability of medical technology to prolong life, the corresponding need to allow the States to serve as

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[29] *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347, 352-353 (1967).

[30] *See People v. Kevorkian*, 447 Mich. 436, 481-482, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr.2d 59, 64 (1992). *See also, Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. banc 1988) ("Broad policy questions bearing on life and death issues are more properly addressed by representative assemblies."), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

laboratories for change becomes paramount. Indeed, as this Court has recognized, "[t]he science of government . . . is the science of experiment, . . . " *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985) (citation and internal quotes omitted). However, if allowed to stand, the Ninth Circuit's opinion will effectively extinguish the power of the States to continue to serve as laboratories for change on an issue that arguably will affect more lives than any issue the States will face in the foreseeable future. *See New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). It will also "invite[ ] an unelected federal judiciary to make decisions about which state policies it favors and which ones it dislikes." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985). At the same time, it will "relegate the States to precisely the trivial role that opponents of the Constitution feared they would occupy." *Garcia*, 469 U.S. at 575 (Powell, J., dissenting) (footnote omitted).

> "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." *Compassion in Dying II*, 79 F.3d 790, 858 (9th Cir. 1996) (Kleinfeld, C.J., dissenting).

III. CONCLUSION

For all the foregoing reasons, amici States respectfully request that the Court grant certiorari in this case.

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Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., PH.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE CALIFORNIA MEDICAL ASSOCIATION, AND THE SOCIETY OF CRITICAL CARE MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE*

Pursuant to Rule 37.2 of the Rules of this Court, the American Medical Association ("AMA"), the California Medical Association ("CMA"), and the Society of Critical Care Medicine ("SCCM") respectfully move for leave to file the attached brief as *amici curiae* in support of the petition for a writ of certiorari submitted by the State of Washington. The respondents, Drs. Harold Glucksberg, Abigail Halperin, Thomas Preston, and Peter Shalit, have refused to consent to the filing of this brief.

The AMA is a private, voluntary, non-profit organization of physicians. It was founded in 1846 to promote the science and art of medicine and to improve the public

health. Its 290,000 members practice in all states and in all fields of medical specialization.

The CMA is a statewide professional organization dedicated to the health of Californians. With 34,000 members, it is the largest state medical association in the country.

The SCCM is the premier professional international organization devoted exclusively to the advancement of multidisciplinary critical care through excellence in patient care, education, research and advocacy. The nearly 9,000 members of SCCM—the intensivists, nurses and allied health professionals involved in the care of the critically ill and injured—blend their knowledge, skill, and expertise into a coordinated effort to achieve the best possible outcome for the patient.

Many of *amici*'s members are deeply interested in, and may be directly affected by, the Ninth Circuit's holding that laws prohibiting physician-assisted suicide are unconstitutional. The decision directly affects not only the Washington statute that was held invalid as applied in this case, but also the similarly worded California, Alaska, Arizona, and Montana statutes,* as well as the common law in the remaining four states of that circuit. Moreover, the statutory prohibitions in these states apparently are comparable to those in force in at least 27 other states (see Pet. App. at A-135 to A-136 n.10) (Beezer, J., dissenting) (citing state statutes).

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* *See* Wash. Rev. Code § 9A.36.060 (felony if a person "knowingly causes or aids another person to attempt suicide"); Alaska Stat. § 11.41.120 (felony if a person "intentionally aids another person to commit suicide"); Ariz. Stat. § 13-1103 (felony for "intentionally aiding another to commit suicide"); Cal. Penal Code § 401 (felony if a person "deliberately aids, or advises, or encourages another to commit suicide"); Mont. Stat. § 45-5-105 (felony if a person "purposely aids or solicits another to commit suicide").

The interest of *amici* in the Ninth Circuit's holding emerges from their role not only in representing American medical professionals but also in developing standards for defining the ethical practice of medicine. For example, at the first official meeting of the AMA in 1847, one of the two principal items of business was the establishment of a code of professional ethics. Since then, generations of physicians have volunteered countless hours to maintain, revisit, and, where appropriate, revise that code. Such efforts resulted, for example, in the 1989 decision of the AMA's Council on Ethical and Judicial Affairs ("Council") to affirm that it was not unethical for physicians to honor the wishes of patients that life-prolonging medical treatment be withheld or withdrawn. See AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* ("*Code of Medical Ethics*") § 2.20 (App. 12a-13a).

In the same tradition, the Council in 1991 began a detailed reassessment of the longstanding ethical prohibition of physician-assisted suicide. The Council's conclusions were set forth in two reports, *Decisions Near the End of Life*, 267 J.A.M.A. 2229 (1992), and *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues in L. & Med. 91 (1994) (App. 2a-11a). This work, in turn, formed the basis for the Council's decision in 1994 to adopt Opinion 2.211, which confirms and clarifies the AMA's position that physicians should not assist patients in committing suicide. *Code of Medical Ethics* § 2.211 (App. 1a). On June 25, 1996, the AMA's House of Delegates voted to affirm that position by a wide margin. *AMA Delegates Vote Overwhelmingly to Oppose Physician-Assisted Suicide*, 5 Health L. Rep. (BNA) 1033 (July 4, 1996).

The CMA, similarly, has vigorously opposed the legalization of physician-assisted suicide, which is prohibited by California law. Notably, CMA's Board of Trustees voted in 1992 to oppose California's "Physician-Assisted Death" initiative (Proposition 161) and, since then, has

consistently affirmed that position. Because California's law prohibiting physician-assisted suicide is threatened directly by the Ninth Circuit's holding, CMA members have an especially significant interest in the disposition of this case.

SCCM's involvement in ethical issues is a long-standing priority of the organization. Position papers and articles on patient triage, appropriateness of life-sustaining treatment and other ethical issues—developed by the SCCM Ethics Committee—have been published in SCCM's peer-reviewed journal, *Critical Care Medicine*, and other prestigious journals. SCCM's initiative to address care at the end of life includes contacting critical care professionals (SCCM members and others) at hospitals and medical centers nationwide to encourage frank discussion about end of life care; expediting the adoption of the multidisciplinary team model of critical care; ensuring that hospital ethics committees are accessible to patients, families, and health care practitioners; and convening "Critical Caring: A Consensus Conference on Care at the End of Life" in Washington, D.C.

The AMA, CMA, and SCCM seek to participate as *amici* in order to ensure that our nation's laws are informed by reasoned and time-tested ethical standards. The AMA has expressed its position before this Court on issues of similar concern, see, *e.g.*, Brief of the AMA *et al.* as *Amici Curiae* in Support of Petitioners, *Cruzan* v. *Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (No. 88-1503), and it submitted an *amicus* brief below in support of the State of Washington's position in this case, Brief of the AMA as *Amicus Curiae*, *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 94-35534). The Ninth Circuit, moreover, devoted a significant portion of the decision below to responding to the AMA's position, Pet. App. A-80 to A-81, A-90 to A-96, and to evaluating, more generally, the potential impact of its holding on the medical profession, Pet. App. A-77 to A-81. For all of these reasons, the AMA, CMA, and SCCM seek the opportunity to present their views as to why this case merits this Court's review. Accordingly, *amici* urge the Court to grant leave to file the *amici curiae* brief that accompanies this motion.

Respectfully submitted,

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QUESTION PRESENTED

Amici Curiae will address the following question:

Whether a terminally ill, competent individual has a constitutionally protected right to obtain the assistance of a physician in order to commit suicide.

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BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE CALIFORNIA MEDICAL ASSOCIATION, AND THE SOCIETY OF CRITICAL CARE MEDICINE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICI CURIAE*

Descriptions of *amici* and their long and continued involvement in considering and setting ethical standards for the medical profession, and in participating in and stimulating debate both within and outside the medical profession on the difficult issues of caring for patients with serious illness and depression, are set forth in the accompanying motion for leave to file this brief. That motion also sets forth a number of reasons why this case is of particular interest to *amici*, including *amici*'s desire to

respond to the Ninth Circuit's extended discussion of the AMA's submission below regarding the impact of this decision upon the medical profession, the AMA's participation before this Court in its consideration of *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), the CMA's direct interest in the fate of California's statutory prohibition of physician-assisted suicide, and the SCCM's longstanding efforts to address and educate physicians and patients regarding medical care at the end of life. Most fundamentally, *amici* are interested in this case because of the profound and harmful impact that the Ninth Circuit's decision will have on the trust between physician and patient that is crucial to the physician-patient relationship and to the integrity of the medical profession.

Amici recognize the imperative of developing adequate medical and social responses to the needs of patients at the end of life. As discussed below, however, they believe that physician-assisted suicide is incompatible not only with the ethical traditions of medical practice but with the long-term interests of patients and physicians. In reaching that conclusion, the AMA, CMA, and SCCM struggled with many of the profound and troubling issues that the court below addressed and that are inherent in the questions presented by the petition. *Amici* respectfully submit that this case, like the parallel case pending on petition for writ of certiorari to the United States Court of Appeals for the Second Circuit (see note 2, *infra*), raises issues of vital importance to physicians and, more broadly, to the nation. Accordingly, *amici* urge the Court to grant the petition.

BACKGROUND—PHYSICIAN-ASSISTED SUICIDE

1. Physician-assisted suicide occurs "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics*: *Current Opinions* § 2.211 ("*Code of Medical Ethics*") (App. 1a); see also AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues in L. & Med. 91, 92 (1994) (App. 3a-4a). What makes physician-assisted suicide distinct from treatments that may result in loss of life is that the physician provides medical assistance *for the purpose* of killing the patient. As such, it is an action fundamentally different from two other types of physician action involving the loss of life.

The first is the provision of palliative treatment that may have the consequence of hastening death, but that is provided to the patient for the purpose of easing the patient's pain. The second is the withholding or withdrawal of life-sustaining treatment at the request of the patient or appropriate surrogate. In each of these two cases, although death is the consequence of the physician's action, the purpose of the action is not to cause death. In the case of palliative care, the purpose of the physician's action is to ease the patient's physical pain. In the case of withdrawal of treatment, the purpose is to respect the patient's wishes that the patient's underlying disease be allowed to take its course without further medical intervention. In neither case does the physician employ the instruments of medicine for the purpose of ending the patient's life. The distinctions between these cases preserve both the physician's role as healer and the patient's right to self-determination. Their recognition is crucial to the definition of the ethical practice of medicine.

2. The ethical injunction against physician-assisted suicide has origins at least as ancient as the Hippocratic Oath, which states that "physicians shall give no deadly drug to any, though it be asked of [them], nor will they counsel such." The profession's modern prohibition is, however, no mere vestige of history. As the AMA's Council on Ethical and Judicial Affairs has stated,

physician-assisted suicide is "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Code of Medical Ethics* § 2.211 (App. 1a). For example, as healer, the physician's role is to provide the patient with appropriate medical treatment when the patient desires it and to relieve pain and provide care designed to comfort the patient, even if further medical treatment is unwanted by the patient. The physician's commitment to support the patient creates a foundation for patient trust that the physician will do whatever possible, consistent with the patient's informed wishes, to promote the patient's health and well-being and to ease the patient's pain.

Permitting a physician to certify a patient as belonging to a death-eligible class, and then to assist that patient in taking his or her life, is incompatible with the physician's healing role. The willingness of many patients to seek medical care is founded on their trust that physicians are committed to preserving life and health. The knowledge that some physicians would willingly assist patients in killing themselves would undermine that trust and would, for example, likely deter or delay some individuals from seeking medical care. Physician-assisted suicide thus ultimately undermines the trust that is essential to the physician-patient relationship.

The consequences to the physician-patient relationship and to the public health of destroying that trust should not be underestimated. As two accomplished bioethicists have concluded,

> 'The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumental and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.'

Decisions Near the End of Life, 267 J.A.M.A. 2229, 2232 (quoting T.L. Beauchamp & J.F. Childress, *Principles of Biomedical Ethics* (3d ed. 1989)).[1]

By way of example, the legalization of assisted suicide could intensify the pressure on gravely ill patients to choose to die in order to relieve their families and friends of the financial and emotional burdens of their illnesses. Recent studies indicate that it is these concerns—rather than intractable pain—that most often motivate patients' requests for physician-assisted suicide. See *"Physician-Assisted Suicide in the United States": Hearing Before the Subcomm. on the Const. of the House Comm. on the Judiciary*, 104th Cong., 2d Sess. (1996) (written testimony of Lonnie Bristow, M.D., President of the American Medical Association); see also Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 Issues in L. & Med. 415, 426-27 (1995). These pressures may be keenly felt by the least-privileged members of our society. As John Pickering, the Chair of the ABA Commission on Legal Problems, noted recently,

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[1] Another noted ethicist recently expressed the same concerns in starker terms:

> Do we really want our doctors to be licensed agents of death? Should they be permitted or encouraged to prescribe (and, later, to inject) poison? Shall the mantle of privacy that protects the doctor-patient relationship, in the service of life, now also cloak decisions for death? Do you want your doctor deciding, on the basis of his own private views, when you still deserve to live and when you now deserve to die, when you should be offered death as a "therapeutic option"? And what about the doctor you would never go to: do you want him also licensed to kill? In short, shall the healing profession become also the death-dealing profession?

"Physician Assisted Suicide in the United States": Hearing Before the Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess. (1996) (written testimony of Leon R. Kass, M.D., Addie Clark Harding Professor, University of Chicago, pp. 2-3).

> [b]efore there can be such truly voluntary choice to terminate life, there must be universal access to affordable health care. The lack of access to or the financial burdens of health care can hardly permit voluntary choice for many. What may be voluntary in Beverly Hills is not likely to be voluntary in Watts.

Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. R. 735, 738-39 & n.17 (1995) (quoting John H. Pickering, *The Continuing Debate Over Active Euthanasia*, Bioethics Bulletin (ABA) 1, 2 (Summer 1994)). The interpersonal and subjective nature of these pressures, moreover, makes them particularly difficult to address through state regulation.

Medical studies further call into question the voluntariness of many requests for assisted suicide. Contrary to the suggestion of the court of appeals, Pet. App. A-74, the desire to hasten death is not a necessary concomitant of serious illness. A physician and leading author on suicide reports that "many patients and physicians displace anxieties about death onto the circumstances of dying"; by assisting dying patients not in suicide but in directly confronting the fear of death, the physician "may focus a patient on what he can achieve in whatever life can still offer." Herbert Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 Issues in L. & Med. 123, 128 (1994). Notably, one study of hospice patients found that the majority "did not want to die; and all those who desired death were suffering from major depression." Osgood, *supra*, at 427; see also Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 New Eng. J. Med. 1100, 1101 (1991); James H. Brown *et al.*, *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psychiatry 208 (1986). Because most physicians have not received extensive psychiatric training, Osgood, *supra*, at 430, there is a significant possibility that they will fail to diagnose treatable mental illness and, consequently,

will assist patients to commit suicide even though their psychological condition could be treated.

The option to assist a patient's suicide also will likely divert the attention of some physicians from providing therapeutic counseling, care, and comfort to their patients. Peter A. Singer & Mark Siegler, *Euthanasia—A Critique*, 322 New Eng. J. Med. 1881, 1883 (1990). If assisting suicide were legitimated, some physicians might be reluctant "to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death." *Decisions Near the End of Life*, *supra*, at 2232. Assisted suicide also could become for physicians an inappropriate "way of dealing with the frustration of being unable to cure the disease." Herbert Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 128. "[B]y making death a medical decision," assisted suicide gives the physician "the illusion of mastery over the disease and the accompanying feelings of helplessness." *Id.* Moreover, in view of the escalating pressures on health care professionals to reduce the costs of treatment, see generally Ezekiel Emanuel, *Cost Savings at the End of Life*, 275 J.A.M.A. 1907 (1996), lifting the prohibition of physician-assisted suicide could reduce the countervailing pressure that would otherwise exist to improve the ability to treat patients with acute pain and depression.

Finally, the needs of the vast majority of patients with serious illnesses can be addressed in ways more compatible with the physician's role as healer. As the AMA's Council on Ethical and Judicial Affairs stated in 1994,

> Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Code of Medical Ethics § 2.211 (App. 1a). A number of studies point out that physicians often fail adequately to manage their patients' pain, Osgood, *supra*, at 428 & nn.36-39, and that most patients who seek to hasten death change their minds when their pain is successfully controlled, *id.* at 429. Indeed, experts in the field of pain control have shown that "almost all terminally ill patients can experience adequate relief with currently available treatments." Judith Ahronheim & Doron Weber, *Final Passages: Positive Choices for the Dying and Their Loved Ones* 102 (1992); see also Robert D. Truog, *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992); *Physician-Assisted Suicide*, *supra*, at 94 (App. at 6a). Through aggressive treatment of pain, which physicians ethically may and should provide even if the medication were to hasten the patient's death, physicians can ease the pain that prompts certain patients to consider suicide. The increasing availability of hospice care and techniques of patient-controlled analgesia, moreover, will likely help significantly to restore patients' sense of autonomy.

REASONS FOR GRANTING THE PETITION

The Ninth Circuit's lengthy decision below is a sweeping and unprecedented constitutional ruling. It is controlling authority for the laws of nine states and, if widely followed, would partially invalidate the laws of most states. See Pet. App. at A-135 to A-136 nn.10-12. Yet the decision lacks solid grounding in the decisions of this Court and conflicts at numerous points with decisions of other courts of appeals and state supreme courts.

Furthermore, the decision rejects as insubstantial one of the core, long-established, and defining principles of ethical medical practice. The opinion's broad language and mischaracterization of existing medical practice has already caused significant confusion and concern within the medical community. If left to stand by this Court, the decision will seriously compromise the ethical practice of

medicine and cause irreparable harm to patients. The Court should therefore grant the petition in this case.[2]

I. THE COURT OF APPEALS' FINDING THAT TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONALLY PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE MERITS THIS COURT'S REVIEW

The Ninth Circuit, sitting *en banc*, invalidated a Washington statute that makes it a felony to "aid[]" another's suicide to the extent the statute applies to physicians who prescribe lethal drugs to patients for the purpose of enabling them to commit suicide. Under the Due Process Clause of the Fourteenth Amendment, the court held that the statute unreasonably interfered with what the court identified as a fundamental liberty interest of terminally ill patients in "the choice of how and when one dies," and, in particular, "in hastening what might otherwise be a protracted, undignified, and extremely painful death." Pet. App. A-9 to A-11, A-113, A-114, A-116. In so holding, the Ninth Circuit misconstrued this Court's decisions in *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), and reached a result on this issue that conflicts with the analysis of the Second Circuit, see *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), *pet. for cert. pending*, No. 95-1858 (filed May 16, 1996), and with the holding of the Michigan Supreme Court in *People* v. *Kevorkian*, 527 N.W.2d 714 (Mich. 1994),

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[2] For the same reasons, the Court also should grant the petition of the State of New York to review the decision in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), *pet. for cert. pending*, No. 95-1858 (filed May 16, 1996). The Second Circuit, although disagreeing with the Ninth Circuit about the existence of a liberty interest in physician-assisted suicide under the Due Process Clause, employs reasoning similar to the Ninth Circuit's analysis of the state's interests to invalidate a comparable New York statute under the Equal Protection Clause of the Fourteenth Amendment.

cert. denied sub nom. Hobbins v. *Kelley*, 115 S. Ct. 1795 (1995), that no such liberty interest exists.

Neither *Cruzan* nor *Casey* provides a basis for finding a constitutional liberty interest in obtaining a physician's assistance to commit suicide. The liberty interest discussed in *Cruzan* is grounded in the common law protection afforded to every person to refuse unwanted medical treatment. 497 U.S. at 269-70. Medical treatment performed without the patient's consent historically has been treated as a battery—a physical invasion of bodily integrity—excusable only in emergency circumstances. *Id.*; see W. Page Keeton, *Prosser & Keeton on the Law of Torts* 39-42, 190 (5th ed. 1984). The right to refuse treatment is the "logical corollary" of this longstanding common law prohibition against medical treatment without the patient's informed consent. *Cruzan*, 497 U.S. at 270.

Physician-assisted suicide has no comparable common law foundation. It has no antecedent, for example, in the common law right to avoid a physical invasion of bodily integrity. Assisted suicide, moreover, has been unlawful in most states for decades, further undermining the view that it is a legitimate form of medical treatment. See Pet. App. A-135 to A-136 & nn.10-13. Given the courts' historic reluctance to recognize a right to obtain medical treatment, see, *e.g.*, *New York State Ophthalmological Soc'y* v. *Bowen*, 854 F.2d 1379, 1389-92 (D.C. Cir. 1988), *cert. denied*, 490 U.S. 1098 (1989), it would be extraordinary if the first medical treatment to be recognized as a constitutional entitlement were a course of drugs intended to kill the patient. The logic of *Cruzan*, therefore, lends no support to the lower court's judgment here.

The Ninth Circuit's reliance on *Casey* also is misplaced. Although *Casey* contains language that, taken out of context, would support not only the liberty interest claimed here but an almost infinite array of interests, see generally Pet. App. A-56 to A-58 (quoting *Casey*, 505 U.S. at 851-53), it is unlikely that the Court intended to bind itself to such a sweeping expansion of the scope of personal liberty. This is particularly true given that the Court elsewhere noted that the liberty interest at issue in *Casey* was "unique," 505 U.S. at 852, and that the Court's judgment only narrowly reaffirmed, chiefly on grounds of *stare decisis*, a previously recognized liberty interest, *id.* at 854-71.

Nor is there any sound basis, factually or legally, for defining a fundamental liberty interest possessed only by those who are "terminally ill." As an initial matter, this class of individuals cannot accurately be defined. The Ninth Circuit's *en banc* decision leaves the definition of this class to the states. Pet. App. A-98 to A-99. As the Ninth Circuit three-judge panel noted, however, "[t]here is wide disagreement in definition of terminally ill among the states." Pet. App. D-18.[3] Moreover, because uncertainty remains an ineluctable aspect of medicine, it is all too often impossible as a practical matter to determine when a person meets any given criteria for terminal illness. And even if, contrary to experience, physicians could meaningfully and reliably identify a class of "terminally ill" patients (however defined), the Ninth Circuit offers no principled constitutional basis for granting only to individuals in that class the right to a physician-assisted suicide. The Ninth Circuit's reliance on the abortion cases, for example, would certainly support the right of any competent individual to obtain a physician-assisted suicide.

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[3] The varying criteria that states employ are vague and unenforceable. For example, Washington law states,

> "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

Wash. Rev. Code § 70.122.020(9).

It is therefore not surprising that the Second Circuit in *Quill* and the Michigan Supreme Court in *Kevorkian* expressly disagreed with the proposition that "either *Cruzan* or *Casey* preordains that the Supreme Court would find that any persons, including the terminally ill, have a liberty interest in suicide that is protected by the Fourteenth Amendment." *People* v. *Kevorkian*, 527 N.W.2d at 728; see *Quill* v. *Vacco*, 80 F.3d at 725 (declining "to identify a new fundamental right, in the absence of direction from the [United States Supreme] Court."); *id.* at 737 (Calabresi, J., concurring) ("[N]either Cruzan, nor Casey, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws [prohibiting physician-assisted suicide] invalid"). The conflict on this point alone merits this Court's review. See Pet. at 20-22.

II. THE COURT OF APPEALS' HOLDING THAT STATES LACK A JUSTIFIABLE INTEREST IN PROHIBITING PHYSICIAN-ASSISTED SUICIDE ALSO MERITS REVIEW

The decision below also merits review insofar as it dismisses the interests relied upon by the State of Washington in support of its prohibition against physician-assisted suicide. The interests and policy concerns that support a continued ban on physician-assisted suicide are numerous and compelling. The Ninth Circuit's result-driven analysis improperly casts them aside in favor of the court's own policy analysis. *Amici* would particularly draw the Court's attention to the tone of the opinion, by turns hostile, sarcastic, and disparaging, as the court rejects the views submitted by the AMA below.[4]

[4] *See, e.g.*, Pet. App. A-80 to A-81 n.95 (chiding the AMA for "sugarcoat[ing]" the facts; suggesting that the AMA's ethical opinions contain "euphemistic" language to "salve the conscience of the AMA" at the expense of the "realities of the practice of medicine"); *id.* at A-95 (deriding "tradition-bound AMA members" for citing to the Hippocratic Oath in view of some of its "preposterous" positions).

Two aspects of the lower court's ruling deserve particular attention. First, central to the Ninth Circuit's analysis (and the linchpin of the Second Circuit's equal protection holding in *Quill*) is the view that there is no meaningful distinction between physician-assisted suicide on one hand and withdrawal of life-prolonging treatment, or the provision of life-shortening analgesia, on the other. Second, the Ninth Circuit expressed confidence that the state and medical profession could protect the public from any adverse consequences that might otherwise ensue from the legalization of physician-assisted suicide. Both conclusions are unwarranted.

1. The Ninth Circuit could "see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life" because "the death of the patient is the intended result as surely in one case as in the other." Pet. App. A-82.[5] Surely the law can be informed by more careful reasoning. It is true that, in each case, death is the result. But it is only the latter act, involving the prescription of a lethal drug, of which it can fairly be said that both the doctor and patient intend to use medical means to cause the death of the patient. By contrast, in the withdrawal of treatment, the patient intends to let the underlying illness take its course *without* further medical intervention. Out of respect for the patient's long-recognized right to be free of unwanted medical intervention, the physician must acquiesce in the patient's judgment. Examples of such judgments include that of the Jehovah's Witness to refuse a necessary blood transfusion, or of a Christian Scientist to refuse life-saving surgery. "To call these judgments [to refuse or withdraw treatment], and the ensuing omission of treatment, 'intending' death distorts what actually hap-

[5] The rejection of these distinctions also formed the basis for the Second Circuit's finding that New York's prohibition of physician-assisted suicide violated the Equal Protection Clause of the Fourteenth Amendment. *See Quill*, 80 F.3d at 727-29.

pens. . . . [I]f I stop shovelling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby intending a driveway full of snow?" Kamisar, *supra*, at 755 & n.90 (quoting Daniel Callahan, *The Troubled Dream of Life* 77-78 (1993)); see, *e.g.*, *McKay* v. *Bergstedt*, 801 P.2d 617, 626 (Nev. 1990) (noting difference between "choosing a natural death summoned by an uninvited illness or calamity and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying"); Pet. App. C-10 n.12 (noting numerous judicial decisions that distinguish withdrawal of treatment from suicide).

The importance of the distinction, and the Ninth Circuit's analytic failure, can be seen in the court's discussion of Nancy Cruzan. In the Ninth Circuit's view, Nancy Cruzan "did not die of an underlying disease" but rather "was allowed to starve to death." Pet. App. A-79 & n.91. From this, the court reasoned more broadly that, when a doctor authorizes withdrawal of life-sustaining treatment, he "intends that, as a result of his action, the patient will die an earlier death than he otherwise would." *Id.*

The court simply missed the crucial point about Nancy Cruzan's case. Our society does not, and never has, forced people to accept medical treatment that would prolong their lives merely because the treatment is available. That principle has taken on added importance as life-prolonging medical technology has become more sophisticated and potentially intrusive. Until recently, an accident victim like Nancy Cruzan, who was comatose and could no longer take food or fluids by mouth, would have died from injuries sustained in that accident. Advances in medical treatment, such as tube feeding, now permit persons so afflicted to survive. But the fact that such treatment is available to those who want it does not mean that, when a person refuses such treatment, the person's death is not caused by the underlying disease or injury. Nancy Cruzan's feeding tube was administered to give her a chance to survive and recover consciousness. When,

after eight years, it became clear that she would never recover, the physicians who removed her feeding tube did so out of respect for her right to stop receiving such assistance.

For similar reasons, the Ninth Circuit also erred in failing to recognize that the administration of aggressive pain control, even when it may have the consequence of hastening death, also differs ethically from physician-assisted suicide. Typically, the provision of medication in doses strong enough to relieve pain will not bring about a patient's death. See Truog, *supra*, at 1680-81. But even in a case where palliative treatment might be said to hasten death or increase the risk of death, where the intention behind the treatment is to alleviate pain, the provision of such treatment is ethical and fully consistent with a physician's role as healer.

Here, too, the Ninth Circuit confused the issue of intent, asserting cavalierly that "doctors are generally permitted to administer death-inducing medication, as long as they can point to a concomitant pain-relieving purpose." Pet. App. A-77. This is incorrect. Where a physician prescribes treatment for the purpose of causing death, the physician has exceeded the bounds of ethical medical practice regardless of what other purpose the physician may "point to." Judge Kleinfeld understood the crucial ethical distinction, and expressed it well by analogy: In deciding to order American soldiers onto the beaches of Normandy, General Eisenhower knew full well "he was sending many American soldiers to certain death," yet he intended by this order not to kill the soldiers but to "liberate the beaches, liberate France, and liberate Europe from the Nazis." Pet. App. A-163 (Kleinfeld, J., dissenting).

2. The Ninth Circuit also underestimated the danger of adverse consequences likely to flow from its decision and overstated the state's ability to cope with them through methods short of prohibiting assisted suicide.

First, by blurring the distinction between aggressive pain management on the one hand and euthanasia on the other, the Ninth Circuit decision may lead many physicians who believe assisting in suicide to be unethical to be unduly cautious in managing their patients' pain. Ironically, because many terminally ill patients do not receive enough analgesia, such a reaction would only increase the number of patients that would seek, needlessly and tragically, to end their pain by ending their lives. In view of the need more aggressively to combat the acute pain suffered by some patients, it is imperative that states be permitted to confirm and reestablish this sound ethical distinction in our nation's laws.

Similarly, the court's ruling that there is no meaningful distinction between honoring a patient's request to withdraw treatment and writing a prescription for lethal drugs may increase some physicians' reluctance to honor patients' requests to withdraw treatment. Such a result would be particularly unfortunate given the years of effort devoted to increasing physicians' acceptance of the patient's right to refuse life-sustaining treatment, and the importance to the medical profession and to the public that such wishes be honored.

More fundamentally, the decision may well lead to significant numbers of cases in which lethal medications are administered to patients without their consent. In this regard, the Netherlands' experience is instructive. Although the Dutch law prohibiting physician-assisted suicide has not been repealed, the Netherlands has permitted its physicians to provide such assistance so long as certain express guidelines and safeguards developed by the medical profession are followed. In 1990, the Dutch Government appointed a committee, chaired by the Attorney General of the Supreme Court, Prof. J. Remmelink, to investigate the administration of euthanasia-related medical practices in the Netherlands. After conducting three large-scale studies, each involving hundreds of physicians, the Remmelink Commission reported that over

1,000 cases of active involuntary euthanasia—that is, the administration of fatal drugs with the intent to kill, performed without the knowledge or consent of the patient—took place in the Netherlands each year, even though medical guidelines specifically prohibited the practice.[6] The Netherlands' experience calls seriously into question the possibility of limiting abuse through mere regulation of physician-assisted suicide.

Moreover, the Ninth Circuit's decision, if upheld, is likely to increase significantly the number of suicides of persons with treatable mental depression and physical pain or who are not terminally ill. Studies report that a number of Dutch physicians assisted in the suicides of patients who were neither physically ill nor suffering from untreatable pain.[7] Of course, one need not look abroad for examples. Cases of physician-assisted suicide carried out under similar circumstances have also been reported in the United States.[8]

The above examples alone should be sufficient to justify a state's decision to prohibit assisted suicide. That evidence confirms that a state at a minimum could rationally decide that physician-assisted suicide provides far more potential for abuse than does withdrawal of un-

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[6] *See* Richard Fenigsen, Comment, *The Report of the Dutch Governmental Committee on Euthanasia*, 7 Issues in L. & Med. 339, 340-42 (1991).

[7] *E.g.*, Herbert Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 123, 129 (discussing assisted suicide of "physically healthy fifty year old [Dutch] woman who had lost her two sons and who had been recently divorced from her husband").

[8] *See, e.g.*, Richard Leiby, *Just How Sick Was Rebecca Badger?*, Washington Post A-1 (July 29, 1996) (reporting county medical examiner's conclusion that autopsy of woman who committed suicide with Dr. Kevorkian's assistance showed no "evidence of medical disease"); Kamisar, *supra*, at 740 (observing that Dr. Kevorkian's first suicide "patient", Janet Adkins, "might easily have lived for many more years" since she was in only initial stages of Alzheimer's disease).

wanted life-prolonging medical treatment. It suggests that physician-assisted suicide cannot and will not, in practice, be limited only to competent patients whose death is imminent and whose request for a prescription for life-ending medication can confidently be described as voluntary. Rather, it strongly suggests that—regardless of the safeguards imposed—assisted suicide may become routine, may involve many patients who are not ill and who are not (or need not be) wracked with pain, may be prompted by displaced anxiety over the fear of death that psychiatric treatment could address, and may result from the decisions of physicians or families rather than patients that such treatment is in the patient's interest.

Although the Ninth Circuit professed concern about "abuse," Pet. App. A-102, the court's purported solution to these profound problems is ironic and unsatisfactory. After riding roughshod for pages over the medical profession's adherence to longstanding ethical principles, the Ninth Circuit blandly asserted "that sufficient protections can and will be developed by the various states with the assistance of the medical profession . . . to ensure that the possibility of error will be remote." Pet. App. A-103 to A-104. Experience to date suggests, however, that such safeguards are not likely to be effective. Moreover, the very fact that the court thought them necessary calls into question its rejection of the seriousness of the state's interest in an outright prohibition.

Even more fundamentally, the lower court's willingness to cast aside a longstanding ethical norm itself seriously undermines the likelihood that professional standards will operate to keep the exercise of the court's newly announced liberty interest from spinning out of control. For example, in one of the Ninth Circuit's most misguided passages, the court suggests that patients would be better off if physicians were given "a choice" as to which ethical standards they will adhere to, thereby enabling patients to seek out physicians who offered the

services they wanted. Pet. App. A-96 & n.112. This view is incompatible with the existence of meaningful ethical standards which, if they are to serve the policing role that the Ninth Circuit envisions in the future, must be applicable to all within the profession.

At bottom, the Ninth Circuit's cynical approach to medical ethics threatens the integrity of medical practice. "No human being can escape the reality of being sick and being cared for. All must seriously contemplate what a divided profession without a common set of moral commitments would mean." Edmund D. Pellegrino, *Rethinking the Hippocratic Oath*, 275 J.A.M.A. 1807, 1809 (1996). Ultimately, uncertainty regarding the vitality of even some physicians' central ethical commitment to preserve the life and health of patients can serve only to undermine the public's trust and confidence in physicians and in the medical profession.

* * * * *

Physician-assisted suicide, appropriately defined, is contrary to basic tenets of the medical profession and to the laws of most states. The Ninth Circuit's faulty case analysis and poorly reasoned assessment of the states' interests strongly suggest that it erred in concluding that patients have a constitutional right to such assistance. But regardless of the merits, the question is of such exceptional national importance that, if the longstanding prohibition, both ethical and legal, on assisted suicide is now to be declared unconstitutional, such a declaration should come only from this Court after plenary consideration of this issue.

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CONCLUSION

For the reasons stated above and in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDICES

APPENDIX A

American Medical Association Opinion 2.211: Physician-Assisted Suicide

Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (*JAMA*. 1992; 267: 2229-2233)

APPENDIX B

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION

Subject: Physician-Assisted Suicide (Resolution 3, A-93)

Presented by: John Glasson, M.D., Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Louis R. Zako, M.D., Chair)

Introduction*

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report, "Decisions Near the End of Life." In that report, the Council concluded that physician-assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not . . . participate in assisted suicide." Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most

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* In accordance with the Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws (I-91), this report may be adopted, not adopted, or referred. It may only be amended, with the concurrence of the Council, to clarify its meaning.

fundamental measures of human value and worth." Similarly, in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.' "

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins. The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull. Other public events quickly followed. Physician-assisted suicide, together with euthanasia, was placed on the public ballot in Washington state, in November 1991, and in California, in November 1992. Both times, voters turned down proposals to legalize physician-assisted dying. In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide. In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician-assisted suicide.

Definitions

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician-assisted suicide, the patient performs the life-ending act, whereas in euthanasia the physician administers the death-causing drug or other agent.

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering,

not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.

Ethical Considerations

Inappropriate Extension of the Right to Refuse Treatment

In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible. The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-

assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.

The Physician's Role

The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity, and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain. Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled. Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain. The patient's treatment

plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decisionmaker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.

Relieving the patient's phychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal phychological and spiritual

support of family and friends." Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members, and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention. Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/or antidepressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued. Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family, and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected, and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation, and other comfort care for the associated discomfort.

"Slippery Slope" Concerns

Permitting assisted suicides opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician-assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands, however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision-maker, since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

Recommendations

In lieu of Resolution 3, A-93, the Council on Ethical and Judicial Affairs recommends that the following statements be adopted and the remainder of this report be filed:

1. Physician-assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
4. Requests for physician-assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling, and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

[A complete list of references can be obtained from the Office of General Counsel.]

APPENDIX C

AMERICAN MEDICAL ASSOCIATION

Opinion 2:20 Withholding or Withdrawing Life-Prolonging Medical Treatment (formerly Opinion 2.18)

Reprinted from Council on Ethical and Judicial Affairs, American Medical Association, *Current Opinions* 13 (1989)

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. If the patient is incompetent to act in his own behalf and did not previously indicate his preferences, the family or other surrogate decisionmaker, in concert with the physician, must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient to die when death is imminent. However, the physician should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the surrogate decisionmaker and physician should consider several factors, including: the possibility for extending life under humane and comfortable conditions; the patient's values about life and the way it should be lived; and the patient's attitudes toward sickness, suffering, medical procedures, and death.

Even if death is not imminent but a patient is beyond doubt permanently unconscious, and there are adequate safeguards to confirm the accuracy of the diagnosis, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or permanently unconscious patient, the dignity of the patient should be maintained at all times. (I,III,IV,V)

(7)

Supreme Court, U.S.
FILED
NOV 12 1996
CLERK

No. 96-110

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington, *Petitioners*,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D., *Respondents*.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED JULY 3, 1996
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CHRONOLOGICAL LIST OF IMPORTANT DATES

January 24, 1994	Plaintiffs' Complaint for Declaratory Judgment and Injunctive Relief filed in U.S. District Court for the Western District of Washington at Seattle
February 3, 1994	Plaintiffs' Motion for Summary Judgment filed
February 19, 1994	Defendants' Answer to Complaint for Declaratory Judgment and Injunctive Relief filed
February 28, 1994	Defendants' Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment and in Support of Summary Judgment for Defendants filed
March 16, 1994	Oral argument on cross motions for summary judgment
May 4, 1994	Order Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendants' Cross Motion for Summary Judgment issued by District Court
May 19, 1994	Stipulation of Parties Regarding Finality of Appeal and Joint Motion for Entry of Final Judgment entered
May 20, 1994	Order Entering Final Judgment entered by District Court

May 25, 1994	Defendants' Notice of Appeal to the United States District Court filed
December 7, 1994	Oral argument before a three-judge panel of the United States Court of Appeals for the Ninth Circuit
March 9, 1995	Opinion of the three-judge panel of the United States Court of Appeals for the Ninth Circuit filed
August 1, 1995	Plaintiffs' Petition for Rehearing and Suggestion for Rehearing En Banc to United States Court of Appeals for the Ninth Circuit granted
October 26, 1995	Oral argument before limited en banc panel of the United States Court of Appeals for the Ninth Circuit
March 6, 1996	Opinion of limited en banc panel of the United States Court of Appeals for the Ninth Circuit filed
March 25, 1996	Order directing parties to brief the issue of whether the case should be reheard before the entire United States Court of Appeals for the Ninth Circuit entered
March 26, 1996	Defendants/Appellants Motion to Stay Mandate filed with the United States Court of Appeals for the Ninth Circuit
May 6, 1996	Order denying stay of mandate unless reconsideration by the entire Court is granted entered by the United States Court of Appeals for the Ninth Circuit

May 14, 1996	Honorable Sandra Day O'Connor, Associate Justice, grants 30-day extension for filing Petition for Writ of Certiorari until July 4, 1996
May 29, 1996	Order entered denying rehearing before the entire Court entered by United States Court of Appeals for the Ninth Circuit
	Order entered by the Honorable Sandra Day O'Connor, Associate Justice, directing that the mandate of the United States Court of Appeals for the Ninth Circuit be recalled and stayed
June 10, 1996	Order entered by the Supreme Court of the United States staying the mandate of the United States Court of Appeals for the Ninth Circuit pending disposition of petition for write of certiorari
June 12, 1996	Amended Order entered denying rehearing before the entire United States Court of Appeals for the Ninth Circuit, with three judges dissenting
July 3, 1996	Petition for Writ of Certiorari filed, docketed July 19, 1996 under cause No. 96-110
October 1, 1996	Order Granting Petition for Writ of Certiorari entered by the Supreme Court of the United States

JAN 24 1994

COPY RECEIVED ON
JAN 24 1994
CHRISTINE O. GREGOIRE
ATTORNEY GENERAL

BY _____
Assistant Attorney General

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

INTRODUCTION

This action seeks a declaratory judgment of unconstitutionality and an injunction barring enforcement of the assisted suicide provision of RCW 9A.36.060. The relevant portion of the statute provides: "A person is guilty of promoting a suicide attempt when he knowingly . . . aids another person to attempt suicide." The statute--by making assistance by physicians, family, or others a felony--prevents competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid a lingering, painful death. The statute denies these individuals the liberty and privacy to decide what to do with their own bodies and lives and forces them to endure pain, anguish, and loss of dignity.

I. JURISDICTION AND VENUE

1.1 This action is brought under the United States Constitution and 42 U.S.C. § 1983 for violation of rights secured by the Fourteenth Amendment. The action seeks a declaratory judgment under 28 U.S.C. § 2201 and an order enjoining enforcement of the assisted suicide provision of the statute.

1.2 This Court has jurisdiction under 28 U.S.C. § 1331. Venue in this district is proper under 28 U.S.C. §§ 1391 and 2201.

II. PARTIES AND INTERESTS AFFECTED

2.1 Compassion in Dying ("Compassion") is a Washington nonprofit corporation. Compassion assists competent, terminally ill adults who choose to hasten their deaths. Plaintiff Jane Roe has requested the assistance of Compassion. Compassion provides information, counseling, emotional support, and personal presence at the time of death. Compassion operates pursuant to a stringent protocol, one requirement being that the medications be self-administered by the individual seeking to hasten death.

Compassion fears that a criminal prosecution could be brought against it for its activities in assisting dying persons to exercise their choice to hasten inevitable death.

2.2 Jane Roe is a mentally competent, terminally ill adult. Jane Roe is a 69-year-old resident of King County, Washington, who is dying of cancer. Jane Roe is a physician and understands her condition and prognosis. Her cancer has metastasized into her bones and is growing rapidly throughout her entire skeleton. She has undergone surgery, chemotherapy, and radiation therapy, but the cancer is incurable. Jane Roe has been almost entirely confined to bed for the past seven months. Movement is intensely painful and her muscles have become so weak they cannot support her. To attempt to alleviate the extreme pain associated with bone cancer, Jane Roe relies on increasing doses of morphine. Even so, she is frequently in severe pain. Jane Roe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of disease and that there is no chance of recovery. Jane Roe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Roe seeks necessary medical assistance in the form of medications prescribed by her doctor to be self-administered for the purpose of hastening her death. Jane Roe desires the presence of members of plaintiff Compassion when she acts to hasten her death.

2.3 John Doe is a 44-year-old artist, living in King County, Washington suffering from AIDS. Mr. Doe has a T-cell count of four, leaving him vulnerable to all manner of infections with almost no natural ability to fight them. Mr. Doe has cytomegalovirus retinitis, which has caused him to lose approximately 70% of his vision to date and will result in blindness. Loss of vision is fatal to Mr. Doe's vocation and avocation, painting. Mr. Doe has

been hospitalized for AIDS-related pneumonia on several occasions. Mr. Doe suffers from chronic skin infections, sinusitis and grand mal seizures related to AIDS. Mr. Doe experiences extreme fatigue and his ability to care for himself is rapidly diminishing. Mr. Doe served as the primary caregiver for his long-term companion who recently died of AIDS at home in Mr. Doe's care. Mr. Doe witnessed firsthand the pain, suffering and loss of bodily function, integrity and personal dignity the disease causes. John Doe has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease and that there is no chance of recovery. John Doe desires medical assistance in the form of medications prescribed by his doctor to be self-administered for the purpose of hastening his death.

2.4 James Poe is a mentally competent, terminally ill adult. James Poe is a 69-year-old resident of King County, Washington, who suffers from chronic obstructive pulmonary disease ("COPD") involving emphysema, bronchitis, and asthma. James Poe also suffers from heart failure caused in part by his COPD. The COPD makes it extremely difficult for James Poe to get enough air. He is connected to an oxygen tank at all times and is required to aspirate medications for hours each day to assist his breathing. He regularly experiences panic attacks associated with the sensation of suffocating and must take medication to calm this terror. James Poe's heart failure causes swelling of his lower extremities, resulting in lost mobility and pain. James Poe's only comfortable moments in life are when he is asleep; however, he can only sleep for two to three hours at a time. James Poe saw his mother die a slow, agonizing death and desires to avoid such a death himself. James Poe has been advised and understands that his illness is a terminal one, that his illness is incurable, and that he is, or soon will be, in the terminal

phase of the disease. When death is imminent and his suffering too great, James Poe wants the right to choose to hasten his inevitable death with medications prescribed by his doctor for that purpose.

2.5 Harold Glucksberg, M.D., is a physician licensed in the State of Washington who practices medicine in a major medical center in Seattle. Dr. Glucksberg specializes in the care of patients with cancer. Many of his patients are terminally ill and suffer severe and chronic pain. Approximately five to ten percent of his patients have cancer related to AIDS. In the regular course of his medical practice, Dr. Glucksberg encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Glucksberg's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Glucksberg from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Glucksberg asserts his own constitutional rights and those of his patients.

2.6 Abigail Halperin, M.D., is a physician licensed in the State of Washington who practices family medicine in Seattle. Some of Dr. Halperin's patients are terminally ill. On occasion she encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Halperin's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Halperin from exercising her best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own

deaths. Dr. Halperin asserts her own constitutional rights and those of her patients.

2.7 Thomas A. Preston, M.D., is a physician licensed in the State of Washington who practices medicine in Seattle. Dr. Preston is a cardiologist and is Chief of the Cardiology Division at a major medical center. Dr. Preston treats patients who are terminally ill and, on occasion, encounters competent, terminally ill patients who express interest in the voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Preston's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Preston from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths. Dr. Preston asserts his own constitutional rights and those of his patients.

2.8 Peter Shalit, M.D., Ph.D., is a physician licensed in the State of Washington who practices internal medicine in Seattle. Approximately thirty percent of his patients suffer from AIDS, an incurable disease. AIDS patients typically suffer from recurrent infections that wear the body down. Many AIDS patients develop cancer. Cancer of the lungs is common among AIDS patients, causing extreme shortness of breath and the terrifying sensation of suffocating. AIDS patients have typically witnessed the deaths of other persons from AIDS and are aware of the course the disease takes. Many of Dr. Shalit's competent, terminally ill patients express interest in voluntary self-termination of life. Under certain circumstances, it would be consistent with Dr. Shalit's medical practice standards to assist these patients' decision to hasten death through the prescription of medications. RCW 9A.36.060 prevents Dr. Shalit from exercising his best professional judgment to prescribe medications to these patients in dosages that

would enable them to act to hasten their own deaths. Dr. Shalit asserts his own constitutional rights and those of his patients.

2.9 The State of Washington is a governmental entity.

2.10 The Attorney General of the State of Washington, Christine Gregoire, is the chief law enforcement officer of the State of Washington and acts under color of the law in enforcing RCW 9A.36.060. She is sued in her official capacity and as representative of all law enforcement officers in the State.

2.11 There exists an actual, justiciable controversy among these parties as to the validity of the statute.

III. CAUSES OF ACTION

3.1 The Fourteenth Amendment protects the right of competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

3.2 The Fourteenth Amendment protects the right of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

3.3 RCW 9A.36.060 denies plaintiffs the equal protection of the laws by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise

this choice, with necessary medical assistance, by directing termination of such treatment.

3.4 Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. Plaintiffs continue to undergo unnecessary pain and anguish. Absent expedited consideration and prompt injunction against enforcement of RCW 9A.36.060, plaintiffs will continue to suffer substantial and irreparable harm and their rights will be finally and fully denied before this Court can rule.

IV. PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

4.1 A declaration that the assisted suicide provision of RCW 9A.36.060 is invalid under the United States Constitution.

4.2 A declaration that the assisted suicide provision of RCW 9A.36.060 violates 42 U.S.C. § 1983.

4.3 An order permanently enjoining defendants, and all who act in concert with them, from enforcing the assisted suicide provision of RCW 9A.36.060.

4.4 An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. § 1988.

4.5 Such other and further relief as this Court deems just.

DATED: January 24, 1994.

PERKINS COIE
David J. Burman
Thomas L. Boeder

By /s/
Kathryn L. Tucker
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	DECLARATION OF RALPH MERO, M.DIV., D.D.
Defendants.	)	

RALPH MERO declares:

1. I am the Executive Director of Compassion in Dying, a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am an ordained Unitarian Universalist minister with graduate degrees from Meadville Lombard Theological School at the University of Chicago. I have been employed in parish ministry with a local congregation and also in community miniseries in health care administration. I am an experienced counselor and trainer of counselors, and have extensive experience in dealing with the personal, familial, and societal aspects of death and dying.

3. Compassion in Dying is a nonprofit charitable organization incorporated in Washington State in April 1993 for the purpose of providing information and counseling to mentally competent, terminally ill adult patients--and their families--in situations where the patients are considering the option of hastening inevitable death. These services are provided at no charge.

4. Terminally ill patients contact Compassion in Dying seeking assistance in shortening the period of suffering before death, and all end-of-life decisions are made by the patient. The family must concur with the patient's decision to hasten death in order for Compassion to be involved. These hastened deaths are facilitated by drugs obtained by, and self-administered by, the patient.

5. Compassion in Dying has stringent eligibility requirements and provides its services only to individuals who are determined by independent medical judgment to be mentally competent and in the end stage of their disease. The eligibility criteria of Compassion are contained in our Guidelines and Safeguards and are set forth as Exhibit 1.

6. Compassion in Dying has stringent Protocol describing the process for assisting with the hastened deaths

of eligible individuals. That Protocol is set forth as Exhibit 2.

7. With members of our Board of Directors, I have been present at several hastened deaths when requested by terminally ill patients and their families. Our presence is provided so that these patients do not have to die alone or to provide emotional support for any family members who are also present.

8. Plaintiff Jane Roe has requested my presence and that of one of our Board members at the time she acts to hasten her death. She is eligible under our criteria. An interview I conducted with Jane Roe on January 20, 1994, about her medical condition and her desires regarding her dying process was video recorded. Plaintiff Jane Roe is very desirous that her true identity not be divulged to the press and public. A complete and unedited copy of that recording will be submitted as soon as a protective order is entered prohibiting disclosure of Jane Roe's true identity.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
RALPH MERO, M.Div., D.D.

COMPASSION IN DYING
PO Box 16483 - Seattle, WA 98116 - 202/624-2775

GUIDELINES AND SAFEGUARDS FOR ASSISTED SUICIDE

A. GUIDELINES

1. Who is eligible?
   a. The patient's condition must be considered terminal in the judgment of the patient's primary-care physician; i.e., the patient suffers from an incurable condition which, according to reasonable medical judgment, will result in death within a reasonable period of time, regardless of continued treatment.
   b. The patient's condition must cause severe, unrelenting suffering which the patient finds unacceptable and intolerable.
   c. The patient must understand the condition, prognosis, and types of comfort care which are available as alternatives to suicide.
   d. The patient's condition and prognosis must be confirmed by one or more physicians who review the records and examine the patient, to the extent that these are possible without compromising the dignity of the patient.
2. Quality of care being received.
   a. It must be clear that the patient's suffering and request for assisted suicide are not the result of inadequate hospice or comfort care.

   b. It must also be clear that the patient's request for assisted suicide is not motivated by lack of adequate health insurance or other economic concerns.
3. The process of requesting assistance.
   a. The request for assistance with suicide must originate with the patient. The request must be made in writing or on videotape on three (3) occasions, with an interval of at lest 48 hours between the second and third requests.
   b. All requests and records will be kept confidential.
   c. Any indication of uncertainty or ambivalence on the part of the patient will cancel the process leading toward assisted suicide.
   d. Requests may not be made through advance directives or by a health-care surrogate, attorney-in-fact, or any other person.
4. Mental health considerations.
   a. Evaluation by a mental-health professional may be obtained to ensure that the patient's request is not motivated by depression, emotional distress, or mental illness.
   b. The patient must be capable of understanding the decision and its implications and must take responsibility for the decision.
5. Family and religious considerations.
   a. If the patient has family members or others with whom he or she is in close personal relationship, their approval must be obtained. Assistance with suicide will not be provided

if there is expressed disapproval by members of the immediate family.

b. Spiritual and emotional counseling may be offered or arranged, depending on the patient's background and beliefs.

6. Who can assist?

The patient may ask for and receive assistance from the individuals in whom he or she has the most confidence and with whom he or she is the most comfortable. Volunteer health-care personnel and others will develop a relationship with the patient in order to become assured that a hastened death is the most appropriate outcome, given the condition and suffering of this particular patient.

B. <u>SAFEGUARDS</u>

1. Terminally ill persons who meet the medical, emotional, and situational criteria for assisted suicide, as outlined in the Guidelines for Assisted Suicide, must make a documented request for assistance with their own suicide, stating in detail the nature of the assistance they need.

2. Three requests must be made. The patient's initial request for assistance must be made in writing or on videotape. This must be followed by two additional requests in writing or on videotape, with at least 48 hours between the second and third requests. Such requests cannot be made through advance directives or by health-care surrogates, family members, or persons other than the patient.

3. COMPASSION representatives trained in working with the terminally ill will meet with the patient making the application--and his or her immediate family, if possible. Copies of the patient's medical records and other pertinent information will be requested.

4. The consulting physician will, through examination of the patient and review of the medical records, verify both the terminal prognosis and the patient's decision-making capacity. This may include consultation with the patient's primary-care physician. The consulting physician will be Board certified or will have equivalent professional experience.

5. If the physician reviewing the case determines a need to rule out depression or any other emotional factors which may indicate confused judgment, the physician shall request an evaluation by a qualified mental-health professional. In such an instance, no effort to assist with suicide will proceed until the assessment has been made and has confirmed the patient's capacity to understand the situation, and until the physician is convinced that the decision is both voluntary and rational. During the course of this process, the patient may receive in-depth counseling and emotional support, but there shall be no effort to assist with suicide during this review.

6. The reviewing physician will ascertain that the request for assistance with suicide does not result from inadequate hospice, palliative, or comfort care, or from inadequate efforts to control pain. If unmanaged pain is an issue, alternative or more intensive palliative care will be recommended.

7. Any sign of indecision or uncertainty on the part of the patient, or opposition on the part of the immediate family, will cancel the process leading toward assisted suicide.
8. The physician and others who have reviewed the records and interviewed the patient will meet in case conference to consider if assistance is needed and warranted. The decision of this group to proceed with assistance must be unanimous.
9. The patient may request that representatives of COMPASSION be present during his or her suicide to provide emotional support and assist with the patient's predetermined plan for ending life. If this is requested, two representatives of COMPASSION will be present. One will keep a written record of the times and events leading up to the moment of death.
10. The actual means of suicide will vary according to the underlying condition of the terminally ill patient and the types of medication available. Assistance with suicide under these safeguards will not involve any means of hastening death which rely on violence.
11. Following an assisted suicide, ongoing emotional and/or spiritual support will be offered to surviving family members or others who so request. Information may also be provided about grief and bereavement resources available in the community.
12. To assure that the process of dying is humane and respectful of the patient's innate sense of human dignity, there shall be no breach of confidentiality disclosing the identity of a patient who has

received assistance with suicide or the identity of persons who provided assistance.

COMPASSION IN DYING

PO Box 16483 - Seattle, WA 98116 - 202/624-2775

PROTOCOL FOR ASSISTED DYING

1. Receipt of initial request for information from patient or family, usually by phone.

2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the **FIRST FORMAL REQUEST FOR ASSISTANCE**, in writing or videorecorded.

3. Assignment of Case Review Team (CRT) consisting of:

    1. Executive Director or substitute from Board of Directors
    2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
    3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.

4. Provision of counseling and emotional support, with second exploration of alternatives.

    Patient must continue determination to commit suicide as only appropriate course of action.

5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.

7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.

8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.

9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*

10. Third review by CRT and report to Board Review Committee.

    Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.

11. Further counseling to be sure that patient wishes to proceed with suicide.

    Fourth review of alternatives.

12. Presence at the time of death if patient is determined to commit suicide and so requests.

COMPASSION IN DYING PROTOCOL FOR ASSISTED SUICIDE

1. Receipt of initial request for information from patient or family, probably by phone.
2. Personal interview with patient, and family if possible, by Executive Director or Board member to explore alternatives and make preliminary determination that patient meets the requirements for assistance from COMPASSION. During this interview, the patient may complete the FIRST FORMAL REQUEST FOR ASSISTANCE, in writing or videorecorded.
3. Assignment of three person Case Review Team (CRT) consisting of:
    1. Executive Director or substitute from Board of Directors
    2. Nurse, mental health professional, or other person experienced in working with the terminally ill.
    3. Trained volunteer, selected to serve as primary liaison with patient, plus physician from Advisory Committee to serve as consultant to CRT.
4. Provision of counseling and emotional support, with second exploration of alternatives.
   Patient must continue determination to commit suicide as only appropriate course of action.
5. **MEDICAL REVIEW.** Examination of patient and medical records by an independent physician to confirm that patient meets medical requirements for assistance from COMPASSION. Consultation with primary care physician, if at all possible.

6. First review by CRT and report to Executive Director or a Board Review Committee appointed for this purpose.
7. **SECOND FORMAL REQUEST FOR ASSISTANCE** from patient, followed by further counseling and emotional support. Third exploration of alternatives. Discussion of specific plan for suicide by prescription medications.
8. Second review by CRT and report to Board Review Committee, if patient plans to continue with suicide.
9. **THIRD FORMAL REQUEST FOR ASSISTANCE** from patient. *At least 48 hours must transpire between 2nd and 3rd requests.*
10. Third review by CRT and report to Board Review Committee. Development of plan for assistance, with clear understanding of COMPASSION'S limits and agreement of family members.
11. Further counseling to be sure that patient wishes to proceed with suicide.
    Fourth review of alternatives.
12. Presence at the time of death if patient is determined to commit suicide and so requests.
13. On-going emotional support for the family, if requested.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C91-119
Plaintiffs,	)	DECLARATION OF JANE ROE
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JANE ROE declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. Jane Roe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 69 years old and am a pediatrician. I received my medical degree from Vanderbilt Medical School in 1953. I have been married for 38 years to my husband who is also a physician. We have 2 grown children.

4. In 1973 a lump in my right breast was determined to be malignant. I underwent surgery to remove my right breast. I then underwent chemotherapy to further treat the breast cancer.

5. To my knowledge, I was free of cancer until the fall of 1988. Efforts to stop the cancer since then have not succeeded. At this time, the cancer has metastasized into my bones and is now found throughout my skeleton, including my skull, spine, rib cage and pelvis.

6. I underwent radiation therapy with fairly good results until early 1993, at which point the cancer became much more painful. Surgery is not an option and chemotherapy cannot be repeated due to bone marrow depression.

7. Beginning in June 1993 and continuing to the present, I have been almost entirely bedridden due to a combination of pain associated with the cancer in my bones and the diminishing strength in my muscles as I use them less and less. I am now unable to walk or use the commode or a bed pan without assistance. My legs are swollen with severe edema and I can scarcely use them. I have developed bed sores as a result of being bed bound. My appetite is poor and I take medications to prevent nausea and vomiting. My vision is often impaired. My left hand is weak. Drowsiness is a frequent problem. I

have an indwelling urinary catheter and am sometimes incontinent of bowel.

8. The pain associated with this cancer is unrelenting. It is a constant, dull pain, interspersed with sharp, severe pain provoked by movement. The site of pain moves as the disease advances.

9. I take a variety of medications to manage pain. There is a tension between taking enough medication to alleviate the pain and retaining an alert mental state. It is not possible to eliminate my pain and for me to retain an alert state.

10. I have experienced a variety of adverse side effects with each treatment regimen. Chemotherapy caused bone marrow depression, fatigue, severe bladder irritation, diarrhea and nausea. Radiation caused further bone marrow depression, requiring repeated blood transfusions; severe bleeding; diarrhea; fatigue; severe sore throat; and first degree skin burns. My medications cause severe constipation, drowsiness, difficulty concentrating, and dry mouth.

11. Since the cancer was diagnosed to the present I have pursued medical treatment. The fact that both I and my spouse are doctors has enhanced my understanding of my condition and options. I believe that I have received good treatment and have benefited from it. At this point, it is clear to me, and based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures. The sole medical treatment available is pain relief, which is not able to eliminate my frequent and severe pain.

12. In November 1993 my doctor referred me for hospice care, and I am receiving home hospice care. To be eligible to receive hospice care I must have no more than six months life expectancy.

13. At the point at which I can no longer endure the pain and suffering associated with my cancer I want to have drugs available for the purpose of hastening my death. I no longer am licensed to prescribe drugs myself, and do not know the best combination of substance and dosage.

14. At the time I act to hasten my death I would like members of Compassion in Dying to be with me and members of my family to provide counseling, emotional support, and any necessary ancillary assistance, such as mixing the drugs to be consumed. I do not want to have to die alone and unsupported. I have made three formal written requests to Compassion in Dying for their assistance as is required by that organization. I participated in a video-taped interview conducted by Ralph Mero of Compassion in Dying on January 20, 1994, which I understand will be submitted in this proceeding. That interview also accurately describes my medical condition and my desires with regard to my dying process.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Mercer Island, this 1st day of February, 1994.

_____

A/K/A JANE ROE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF JOHN DOE
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JOHN DOE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. John Doe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 44 years old and am an artist.

4. I was diagnosed HIV positive in 1988 and diagnosed with AIDS in 1991. I have a T-cell count of 4, which means I have almost no immune system function.

5. My first major illness associated with AIDS was pneumocystic carinii pneumonia, which caused me to be hospitalized for approximately six weeks in the summer of 1992.

6. I experienced a second bout with AIDS-related pneumonia, nocardia, in January 1994. This illness required hospitalization for a period of almost two weeks.

7. I have had cytomegalovirus (CMV) retinitus [sic] since May 1993. This is destroying my retinas, and I am losing my vision. At the present time, I have lost 70% of my vision. I have been advised that I will lose 100% of my vision from this condition.

8. Loss of vision is fatal to my ability to paint.

9. I suffer chronic, severe sinus infections which I am unable to overcome because of my compromised immune state.

10. Also related to my AIDS, I suffer chronic skin infections and grand mal seizures.

11. In addition, my medical conditions leave me extremely fatigued. I live alone and I have noticed that my ability to care for myself is rapidly diminishing.

12. My long-term companion died of AIDS in June 1991. He was bedridden for six months prior to his death. He remained at home throughout his illness, and I was his

primary caregiver. He suffered from wasting syndrome, and at the time of his death he weighed only 60 pounds. I cared for his every physical need. I witnessed first-hand the pain, suffering, anguish, and loss of dignity of dying from AIDS. That experience, as well as my observation of my grandfather's death from diabetes, which included multiple amputations, loss of vision and loss of hearing, have led me to decide that when my inevitable dying process becomes unbearable, I wish to hasten that process.

13. My doctor has advised me that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

14. It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death.

15. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at [not legible], this 1st day of February, 1994.

_____

A/K/A JOHN DOE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	DECLARATION OF JAMES POE
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

JAMES POE declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. James Poe is not my real name; I use this fictitious name to protect my privacy.

3. I am 69 years old. I was a sales representative in the steel industry for all of my working life. My hobby of choice was fishing and, until my illness, I was an avid fisherman year-round.

4. I have suffered from emphysema for approximately nine years. My emphysema makes it extremely difficult for me to breathe. I have a constant sensation of suffocation.

5. In 1990, I underwent lung capacity testing and my doctor advised me that I had only 10 to 20 percent of lung function at that time.

6. I am connected to an oxygen tank at all times and I aspirate medications through a nebulizer for hours every day to facilitate my breathing.

7. Notwithstanding these measures to improve my breathing, I continue to be unable to get enough air and suffer panic associated with air hunger. I take medications, including morphine, regularly to calm the terror associated with the sensation of suffocation.

8. In addition to my emphysema, I suffer from heart failure related to my pulmonary disease. This condition obstructs the flow of blood to my extremities. I experience extreme leg pain and discomfort and am housebound.

9. The only comfortable times are when I am asleep. However, I have difficulty sleeping longer than two to three hours at a time.

10. Because of my condition, I am restricted to my home and have been for the past year.

11. I am not eligible for lung transplant because of my heart condition.

12. My doctors have advised me that I am in the terminal phase of this disease. It has been explained to me that there are no cures.

13. When my condition becomes unbearable, I wish to take drugs prescribed by my doctor for the purpose of hastening my death.

14. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end of life decisions.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Wa., this 1 day of Feb. 1., [sic] 1994.

_____

A/K/A JAMES POE

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF HAROLD GLUCKSBERG, M.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

HAROLD GLUCKSBERG declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in oncology, which is the treatment of persons with cancer.

3. I received my medical education at the Buffalo Medical School in the State of New York, graduating in 1964.

4. I completed a Fellowship in hematology and oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1970.

5. I then completed a Senior Fellowship in oncology in the Department of Medicine at the University of Washington School of Medicine in Seattle, Washington in 1971.

6. I served as an Instructor and Senior Fellow in Medicine at the University of Washington School of Medicine in Seattle, Washington from 1971 through 1973.

7. During the years 1973 through 1975, I served as Assistant Professor of Medicine at the University of Washington School of Medicine.

8. From the years 1975 through 1976, I served as a Senior Lecturer in the Department of Medicine at the University of Dar Es Salaam in Tanzania, Africa.

9. I then served as Assistant Professor in Medicine at the University of Washington School of Medicine in Seattle, Washington and held that position through 1979.

10. During the years 1976 through 1979, I was an Assistant Member of the Fred Hutchinson Cancer Research Center in Seattle, Washington.

11. I served as an Attending Physician in the emergency departments of three New York hospitals during the years 1980 through 1982.

12. I acted as Regional Medical Officer for the Peace Corps in Senegal, Mali, Gambia, and Mauritania during the years 1982 through 1984.

13. Since 1985, I have practiced primary care adult medicine specializing in medical oncology at the Pacific Medical Center in Seattle, Washington. During this period, I have also served as Clinical Assistant Professor at the University of Washington School of Medicine.

14. I am certified by the National Board of Medical Examiners (1965), the American Board of Internal Medicine (1974), and the American Board of Medical Oncology (1979). I am licensed to practice medicine in Washington, New York and New Jersey.

15. I have published numerous articles and papers in medical journals. My full curriculum vitae is attached hereto as Exhibit 1.

16. Dying of cancer is usually very slow, occurring over months rather than days or weeks. General problems faced by most cancer patients include progressive loss of appetite, weight, and independence, and increasing pain and fatigue. In addition, there are a myriad of other problems related to the specific sites of the cancer. Those with cancer of the lung, for example, face terrible shortness of breath and cough. Those with a brain cancer often have excruciating headaches, seizures and progressive loss of brain function. Cancer usually progresses steadily and slowly. The cancer patient is fully aware of his or her present suffering and anticipates certain future suffering. The terminal cancer patient faces a future that can be terrifying. Near the end, the cancer patient is usually bedridden, rapidly losing mental and physical functions, often in excruciating, unrelenting pain. Pain management at this stage often requires the patient to choose between enduring unrelenting pain or surrendering an alert mental

state because the dose of drugs adequate to alleviate the pain will impair consciousness. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

17. I occasionally encounter patients dying of cancer who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their deaths and avoid prolonged suffering. These patients cannot hasten their death without assistance or could do so but only at the risk of increased pain and anguish to themselves and their families.

18. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

19. Under the statute prohibiting assisting suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

20. One patient of mine, whom I will call Jones, a fictitious name, was a 34-year old man dying of AIDS and lymphoma. I treated him during the last year of his life, the final four months of which were excruciatingly painful. Patient Jones had wasted away and suffered from CMV retinitis, which causes blindness. Patient Jones did not want to end his days in a lingering drug-induced stupor, the option available to him if he entered the hospital and was given continuously increasing amounts of morphine intravenously. Patient Jones requested that I prescribe drugs that he could take to hasten his inevitable death. As his

treating doctor, it was my professional opinion that patient Jones was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute I was unable to assist him in this way. Patient Jones ended his life by jumping from the West Seattle bridge. His physical condition was such that he could not have accomplished this without assistance, and it is my belief that he was aided by close family members. Such a violent end of life is inhumane for the patient and for his loved ones. In my opinion, patient Jones suffered more by dying in this manner than he would have if he had been able to self-administer drugs prescribed for the purpose of hastening his death.

21. Furthermore, patient Jones ran the risk of failing in his effort to hasten his death without medical assistance and could have suffered grievously if his effort had been unsuccessful.

22. Another patient of mine, whom I will call Smith, a 60-year-old man dying of metastatic lung cancer, was suffering terribly and requested that I prescribe drugs that he could take to hasten his inevitable death. Patient Smith was opposed to experiencing a lingering death with consciousness impaired by morphine. As his treating doctor, it was my professional opinion that patient Smith was competent to choose to shorten his period of suffering before death by taking drugs prescribed for that purpose. I felt that I should accommodate his request by prescribing such drugs. However, because of the statute, I was unable to assist him. Patient Smith's death dragged on for seven days, most of which was spent in a morphine-induced stupor, exactly as he had feared and desired to avoid.

23. The statute kept these patients from making fundamental decisions about medical care, their lives, their suffering and their dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington, this 2nd day of February, 1994.

/s/
HAROLD GLUCKSBERG, M.D.

Name: Harold Glucksberg, M.D.

Birthdate:	October 18, 1939
Birthplace:	Montreal, Canada
Domestic Status	Married, 2 children
Citizenship:	Naturalized, 1957, Brooklyn, New York

Education:

1956 - 1957:	City College of New York
1957 - 1960:	Queens College of New York
1960 - 1964:	M.D., Buffalo Medical School, New York

Research and Professional Experience:

1964 - 1965:	Internship in Medicine, King Country Hospital,New York City
1965 - 1966:	Resident in Medicine, King Country Hospital New York City
1966 - 1969:	Internal Medicine, U.S. Army
1969 - 1970:	Fellow in Hematology and Oncology, Department of Medicine, University of Washington School of Medicine, Seattle, Washington
1970 - 1971:	Senior Fellow in Onocology [sic], Department of Medicine, University of Washington School of Medicine, Seattle, Washington

EXHIBIT 1

1971 - 6/73:	Instructor and Senior Fellow in Medicine, University of Washington School of Medicine, Seattle, Washington
7/73 - 6/75:	Assistant Professor of Medicine, University of Washington School of Medicine
7/75 - 6/76:	Senior Lecturer, Department of Medicine, University of Dar Es Salaam, Tanzania, Africa, (Sabbatical)
7/76 - 12/79:	Assistant Professor of Medicine, University of Washington School of Medicine, Seattle, Washington
8/76 - 12/79:	Assistant Member, Fred Hutchinson Cancer Research Center, Seattle, Washington
4/80 - 10/80:	Assistant Professor of Nutrition, Tulane Medical School, Co-Director National Nutrition Center of Zaire
10/80 - 7/81:	Attending Physician, Emergency Center Maimonides Medical Center, Brooklyn, New York
9/81 - 7/82:	Attending Physician, Emergency Center, Coney Island Hospital, Brooklyn, New York
1/82 - 7/82:	Attending Physician, Emergency Department, Brooklyn Jewish Hospital, Brooklyn, New York
8/82 - 11/84:	Regional Medical Officer for Peace Corps (Senegal, Mali, Gambia and Mauritania)
1/85 - Present:	Primary Care, Adult Medicine, Medical Oncology Pacific Medical Center, Seattle, Washington

Clinical Assistant Professor University of Washington, School of Medicine

Military Status:

1966 - 1969: Internal Medicine, U.S. Army

Honors:

Gibson Honor Society; Mosby Book Award

Board Certification:

1965	Diploma of the National Board of Medical Examiners
1974	American Board of Internal Medicine
1979	American Board of Medical Oncology

Licensure:

Washington, New York, New Jersey

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Harold Glucksberg, M.D.

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11. Fefer, A., Thomas, L.D., Buckner, C.D., Storb, R., Neiman, P., Glucksberg, H., Clift, R.A. and Lerner, K.G.: Harrow transplants in aplastic anemia and leukemia. Semin. Hematol. 11: 353-367, 1974.

12. Storb, R., Thomas, E.D., Buckner, C.D., Clift, R.A., Fefer, A., Glucksberg, H. and Neiman, P.E.: Transplantation of bone marrow in refractory marrow failure and neoplastic diseases. Am. J. Clin. Pathol. 62: 212-217, 1974.

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF ABIGAIL HALPERIN, M.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

ABIGAIL HALPERIN declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in family medicine and practice in Seattle, Washington.

3. I received my medical education at Albert Einstein College of Medicine in New York, completing my degree in 1983. Following graduation from medical school I completed a family practice residency at Swedish Hospital Medical Center in Seattle, Washington.

4. I then served as a staff physician at an international clinic in Kathmandu, Nepal from 1986 until 1987.

5. In 1987 I became a staff physician at Pacific Medical Clinic in Bellevue, Washington.

6. In 1988 I moved my practice to Uptown Family Practice in Seattle, Washington, which became Providence Uptown Medical Care Center in May 1992, where I continue to practice. I hold the position of Medical Director and Staff Physician.

7. I am licensed to practice medicine in the state of Washington; am certified by the American Board of Family Practice (1988); and am a member of the King County Medical Society and the American Academy of Family Physicians.

8. I hold an appointment as a Clinical Faculty member at the University of Washington School of Medicine, a position I have held since 1990.

9. In my medical practice, I occasionally treat patients with terminal illnesses, including cancer and AIDS.

10. Patients dying of both these diseases experience a steady degeneration of functional ability, increasing pain, fatigue and mental anguish.

11. At a certain point in the progression of many cancer patients' illness, there are no further curative treatment options. There are no curative treatment options for AIDS patients.

12. When curative treatments are not available, a variety of care options to maximize the patient's well being and comfort are available, however, at a certain point in the course of these diseases most patients are not able to be kept comfortable while maintaining a clear consciousness; the amount of pain medication necessary to resolve the pain causes loss of mental alertness and sometimes consciousness. Thus, these patients face the choice of enduring intractable pain or surrendering an alert mental state. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor.

13. For some terminally ill patients, physical pain is a concern secondary to their mental anguish over their helplessness and loss of independence, dignity and autonomy.

14. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to shorten the period of suffering before death. These patients either cannot hasten their death without assistance or could do so only at the risk of increased anguish and pain to themselves and their families.

15. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death as

an alternative to continuing palliative care if the patient so chooses.

16. Under the statute prohibiting assisted suicide, my fulfillment of this professional responsibility might expose me to criminal prosecution. The statute deters me from treating these patients as I believe I should and deprives my patients of their freedom to choose this type of medical care.

17. I recently had an experience where, in my professional judgment, a terminally ill patient of mine should have been able to choose to hasten her inevitable death with drugs prescribed for that purpose but was denied that option by the statute:

a. Patient Smith (a fictitious name) was a woman in her eighties with metastatic breast cancer.

b. Patient Smith had surgeries to remove both breasts and two courses of chemotherapy.

c. Notwithstanding this aggressive surgical and medical treatment, the cancer metastasized and was causing progressive weakness, fatigue and loss of functional abilities.

d. Patient Smith had always been active and independent; she expressed that she did not want to lose her independence and end her life in a hospital, subject to futile medical care; she desired the ability to control the manner and time of her death and requested that I prescribe drugs that she could take to hasten her inevitable death.

e. As patient Smith's primary care doctor, it was my professional opinion that she was mentally competent to choose to shorten the

period of suffering before death. I felt that I should accommodate her request by prescribing such drugs. However, I was deterred from assisting this patient by the statute.

f. Patient Smith acted on her own to hasten her death, by securing a plastic bag over her head and suffocating.

g. In my opinion it is likely that patient Smith suffered more by dying in this manner than she would have if she had been able to self-administer drugs prescribed for the purpose of hastening her death.

h. Furthermore, patient Smith ran the significant risk of failing in her effort to hasten her death without medical assistance and could have suffered disastrous consequences if her effort had been unsuccessful, such as oxygen deprivation-induced brain damage, which would have left her significantly mentally impaired and dependent on the type of intensive, invasive medical care and technology she most feared.

i. The statute kept patient Smith from making fundamental decisions about her medical care, her life and autonomy, her suffering, her dignity, and her death. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February, 1994.

/s/
ABIGAIL HALPERIN, M.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	DECLARATION OF THOMAS A. PRESTON, M.D.
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

THOMAS A. PRESTON declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am a medical doctor specializing in cardiology and am Chief of Cardiology at Pacific Medical Center in Seattle, Washington.

3. I received my medical education at the University of Pennsylvania, graduating in 1962.

4. Following graduation from medical school I completed an internship, residency and fellowship at the University of Michigan.

5. I served as a Special Research Fellow at the National Heart Hospital Institute of Cardiology in London, England, during 1967 and 1968.

6. Upon my return to the United States in 1968 I served as an Instructor of Internal Medicine, specializing in cardiology, at the University of Michigan through 1969. I then became Assistant Professor of Medicine at the University of Michigan and served in this capacity through 1972.

7. I served as Chief of the Cardiology Section at the Veterans Administration Hospital in Ann Arbor, Michigan, from 1968 through 1972.

8. From 1973 until 1980 I served as Associate Professor of Medicine at the University of Washington. Since 1980 I have held the position of Professor of Medicine at the University of Washington.

9. I served as Co-Director of the Division of Cardiology at Harborview Medical Center, Seattle, Washington from 1973 through 1975.

10. From 1975 through 1980 I served as Co-Director of cardiology at the United States Public Health Service Hospital in Seattle, Washington.

11. From 1980 through the present I have been Chief of the Cardiology Division at Pacific Medical Center in Seattle, Washington.

12. I have received numerous honors for medical teaching and writing and have published numerous articles and books in my field of professional expertise. My complete curriculum vitae is attached hereto as Attachment 1.

13. I am board certified in Internal Medicine (1971) and Cardiovascular Medicine (1974).

14. I am currently licensed to practice medicine in Washington. I am a Fellow of the American College of Cardiology and the American Heart Association Council on Clinical Cardiology.

15. In my medical practice I regularly treat patients dying from cardiopulmonary illnesses. Such patients commonly experience chest pain, breathlessness, dizziness, fainting and extreme weakness. The heart of this type of patient is so weak it can work no harder than it does at rest, rendering the patient unable to accomplish the smallest physical task or able to do so only with extraordinary effort, gasping for air. It is not uncommon, for example, for such patients to be unable to change position in bed. There is no chance of recovery for such patients unless a heart transplant, a treatment option available to only a small subset of patients, is performed. The terminal phase of heart failure can last for several months, and most patients know during that time that they are not eligible for a transplant.

16. I occasionally encounter terminally ill patients who have no chance of recovery, whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis, who desire to hasten their deaths and avoid prolonged suffering, and who cannot do so without

assistance or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statute has caused me to do less than I otherwise would for these patients.

19. The statute has resulted in patients of mine dying tortured deaths.

20. The following example is illustrative of situations I have experienced in my career:

a. Patient Jones (a fictitious name) had been in my care for approximately four years.

b. Patient Jones suffered for three months in the final stages of heart disease, unable to get enough air, gasping even under an oxygen mask worn at all times.

c. Patient Jones requested my assistance in hastening his inevitable death by prescribing drugs he could take for that purpose.

d. Patient Jones was not eligible for a transplant, and had no chance of recovery. The patient understood this.

e. Patient Jones was suffering terribly, and the suffering could not be relieved. It was my professional opinion as his treating doctor that patient Jones was mentally competent to make a choice with respect to shortening his

period of suffering before inevitable death. I felt I should accommodate his request.

f. Nonetheless, I was deterred from assisting patient Jones by the statute.

g. The statute kept the patient from making fundamental decisions about the patient's own medical care, his life, his suffering and his dignity. The statute kept me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, this 1 day of February, 1994.

/s/
THOMAS A. PRESTON, M.D.

CURRICULUM VITAE

THOMAS A. PRESTON, M.D.
SSN# 198-24-8933

Birth Date: June 17, 1933

Birthplace: Philadelphia, Pennsylvania

Citizenship: U.S.A.

Education:		
	Swarthmore College Swarthmore, Pennsylvania,	1951-55
	University of Pennsylvania Philadelphia, Pennsylvania	1958-62
	B.S. Electrical Engineering	1955
	M.D. University of Pennsylvania	1962

Marital: Married (Molly), two daughters

Military Service:

U.S. Army	1956-58

Postgraduate Training:

Internship:	University of Michigan Medical Center	1962-63
Residency:	University of Michigan Internal Medicine	1963-66
Fellowship:	University of Michigan	1966-67
Specialty:	Special Research Fellow National Heart Hospital Institute of Cardiology London, England	1967-68

ATTACHMENT 1

Faculty Positions:

Instructor in Internal Medicine (Cardiology), University of Michigan	1968-69
Assistant Professor of Medcicine [sic] University of Michigan	1969-1972
Associate Professor of Medicine University of Washington	1973-1980
Professor of Medicine University of Washington	1980-

Hospital Positions:

Chief, Cardiology Section Veterans Administration Hospital Ann Arbor, Michigan	1968-1972
Co-Director, Division of Cardiology Harborview Medical Center Seattle, Washington	1973-1975
Co-Director, Cardiology U.S.P.H.S. Hospital Seattle, Washington	1975-80
Chief, Cardiology Division Pacific Medical Center Seattle, Washington	1980-

Honors:

American College of Cardiology Young Investigator Award Second Place	1966
University of Michigan Medical Center Resident Achievement Award	1966
University of Michigan Medical School Senior Class Award for Best Teacher	1970, 1972
University of Michigan	1971

Distinguished Service Award	
University of Michigan Medical Center Resident Award to Outstanding Faculty Teacher	1972
University of Washington Medical School Senior Class Award to Outstanding Clinical Teacher	1974,75, 1977,78
The National Association of Science Writers "Science-in-Society" Journalism Award	1983

Administrative Service:

University of Michigan Medical School Senior Counselor	1970-72
University of Michigan Medical School Mentor, Class of 1974	

Board Certification:

Diplomate, American Board of Internal Medicine	1971
Subspecialty Board Certification: Cardiovascular	1974

Licensure:

Pennsylvania (inactive)	1963
Michigan (inactive)	1964
Washington	1973

Organizations:

Fellow
American College of Cardiology

Fellow, American Heart Association
Council on Clinical Cardiology

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Thomas A. Preston, M.D.

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF PETER SHALIT, M.D., Ph.D.
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

PETER SHALIT declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Washington in 1985.

3. Prior to obtaining my medical degree, I received a Ph.D. in Genetics from the University of Washington in 1981. While pursuing my Ph.D. I served as a National Science Foundation Fellow and a National Institute of Health Trainee.

4. After obtaining my medical degree I completed an internship in the Department of Psychiatry and a residency in the Department of Medicine at the University of Washington in Seattle, Washington.

5. From 1989 to 1990 I served as Chief Medical Resident at Providence Medical Center in Seattle, Washington.

6. Since 1990 I have been in private practice specializing in general internal medicine in Seattle, Washington. I hold staff privileges at Swedish Hospital Medical Center and Providence Medical Center.

7. I am certified by the American Board of Internal Medicine (1989) and am licensed to practice medicine in the State of Washington.

8. I have served as the Medical Director of the Seattle Gay Clinic since 1989.

9. I have served as a Clinical Instructor in Medicine in the Division of Allergy and Infectious Diseases, Department of Medicine, University of Washington since 1990.

10. I have served as Attending Physician at the Madison Clinic, an HIV clinic affiliated with Harborview Medical Center in Seattle, Washington, since 1990.

11. A substantial portion of my private practice involves treatment and care of persons with HIV infection and AIDS.

12. Infection with HIV, the Human Immunodeficiency Virus, produces progressive destruction of the immune system, leading to a condition known as the Acquired Immune Deficiency Syndrome, or AIDS, which is inevitably fatal. Persons with AIDS are vulnerable to a variety of unusual infections, cancers, and other syndromes such as dementia (progressive loss of cognitive function), wasting (chronic diarrhea/weight loss), and peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs). Death is often preceded by a prolonged period of illness and debility, especially as medical science becomes better at preventing and treating AIDS-related infections.

13. Patients with AIDS may die in many different ways. Many suffer from Kaposi's Sarcoma, a common AIDS-related cancer. These patients frequently die from invasion of this cancer into the lungs, causing progressive difficulty breathing and ultimately death by suffocation. Many die of pneumonia, which also causes the patient to essentially suffocate. Many with wasting or dementia basically die of starvation and dehydration, a process that can take weeks and can be excruciating; some of the patients lose so much weight that they appear skeletal and their bones may break through their skin. Still others die as the result of some massive infection that resists treatment.

14. Many AIDS patients who will die of the above-described causes also suffer from conditions which themselves cause extreme pain and suffering. Examples include CMV retinitis, which leads to loss of vision and eventually blindness; neuropathy, which sometimes causes

pain so agonizing that it can be relieved only by a dosage of narcotics which impairs consciousness; Kaposi's Sarcoma of the skin, which can produce severe disfigurement and pain from swollen tissues and open, weeping skin lesions.

15. Medicines can palliate the dying process in many cases. The majority of the time, I am able to ameliorate the symptoms of a dying patient so that the patient can be relatively free from pain and discomfort while dying. However, in some cases, the pain, discomfort, and loss of dignity can be relieved only with drugs which render the patient unconscious; in some cases even such aggressive use of drugs does not bring relief. In my five years of practice I have had numerous AIDS patients receiving hospice care who repeatedly express frustration at how long the process is taking, and how painful, uncomfortable, and humiliating it is. Some of these patients have made repeated requests that their dying process be hastened.

16. I occasionally encounter terminally ill patients who have no chance of recovery whom I know to be mentally competent and able to understand their condition, diagnosis, and prognosis who desire to hasten their death and avoid prolonged suffering. These patients cannot hasten their death without assistance, or could do so but only at the risk of increased anguish and pain to themselves and their families.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

18. Under the statute prohibiting assisted suicide, fulfillment of this professional responsibility might expose

me to criminal prosecution. The statute deters me from treating these patients as I believe I should.

19. The statute has resulted in patients of mine dying tortured deaths.

20. One patient of mine, whom I will call Smith, a fictitious name, lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. Patient Smith's friends stopped visiting him because it gave them nightmares. Patient Smith's agonies could not be relieved by medication or by the excellent nursing care he received. Patient Smith begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that patient Smith was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the statute, I was unable to assist him and he died after having been tortured for weeks by the end-phase of his disease.

21. Such a prolonged dying period is inhumane to the patient, who must suffer against his wishes, and to the loved ones, who frequently express the belief that "we are kinder to our pets than we are to the terminally ill." After death, the survivors have guilt about the suffering their dying loved-one endured, and the doctor feels remorse that the patient's suffering could not have been better relieved.

22. More than once I have had an AIDS patient commit suicide relatively early in the course of the disease, apparently fearing that a death like patient Smith's will be their fate. Feeling unable to discuss their fears with me or with their family, and anticipating an illness which will end in unrelieved suffering without the possibility of assisted

voluntary exit, these individuals prematurely end their lives on their own, usually through a violent means. They leave behind grief-stricken family members who have not had the opportunity to say good-bye, and a doctor who wishes he could have prevented their premature death by committing to help them through the subsequent stages of their illness, including the promise of provision of the means of release from unbearable suffering should they so choose at that time.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 1st day of February, 1994.

/s/
PETER SHALIT, M.D., Ph.D.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	DECLARATION OF KATHRYN L. TUCKER
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

KATHRYN L. TUCKER declares:

1. I am counsel to plaintiffs in this matter, am competent to testify and do so of my own personal knowledge.

2. The three terminally ill plaintiffs in this lawsuit appear with fictitious names. These individuals desire that their true identities not be revealed.

3. In support of Plaintiffs' Motion for Summary Judgment, declarations of each of the terminally ill plaintiffs are submitted.

4. The signature page of the declaration of each terminally ill plaintiff has been redacted to conceal the true name of the plaintiff. The originals of each of these signature pages are maintained at my office. This is necessary to maintain the privacy of the terminally ill plaintiffs.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, WA, this 2 day of February, 1994.

/s/
KATHRYN L. TUCKER

No. 88-605

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1988

WILLIAM L. WEBSTER, et al.,
Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, et al.,
Appellees.

On Appeal from the United States Court of Appeals for the Eighth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN FERTILITY SOCIETY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN SOCIETY OF HUMAN GENETICS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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EXHIBIT A

Accordingly, the statute is unconstitutional. See *Colautti v. Franklin*, 439 U.S. 379 (1979).

B. Section 188.205 of the Missouri statute, which the court of appeals held literally precludes a physician from "consulting," i.e., making any comment, about having an abortion unless necessary to save the mother's life, is unconstitutional. The statute clearly interferes with a physician's ethical obligations to discuss fully and accurately all information necessary to permit the patient to make an informed treatment choice. By mandating "a state-imposed blackout on the information necessary to make a decision" (851 F.2d at 1080), Section 188.205 forces a constitutionally impermissible "straightjacket" upon the physician's efforts fully to inform his or her patient. *City of Akron*, 462 U.S. at 445; *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976).

ARGUMENT

I. INDIVIDUALS HAVE A FUNDAMENTAL RIGHT TO MAKE DECISIONS ABOUT THEIR MEDICAL CARE, AND STATE LAWS WHICH INTERFERE WITH THAT RIGHT CAN BE JUSTIFIED ONLY IF THEY ARE NARROWLY TAILORED TO FURTHER A COMPELLING STATE INTEREST.

Appellants and their *amici curiae*--particularly the United States--ask this Court to overrule a decision interpreting the Constitution: *Roe v. Wade*, 410 U.S. 113 (1973). In so doing, they ask the Court to take two major steps. First, they propose altering the balance struck previously by the Court between the interests of the pregnant woman and those of the state. Second, they ask the Court to declare that no fundamental privacy right exists in this case at all. They make this second, extraordinary request because they believe that the privacy right

recognized in *Roe* cannot properly be derived from the Constitution. See U.S. Brief at 9-24.

Given the diversity of views of *amici's* members, this brief does not take a position on whether the balance of interests struck in *Roe* should be modified. However, *amici* firmly believe that the Court should reject the invitation of the federal government to deny constitutional protection to the well-established right of privacy that this Court applied in *Roe v. Wade*.

In the first place, the holding of this Court on the privacy issue was a common sense application of settled constitutional principles to a situation where a woman must make an individual choice about a matter which the Court found would have profound implications for her health and life. Since the same profound individual implications the Court identified in 1973 still exist (see *supra* at 3-23), the decision should be reaffirmed. Second, the holding on the privacy issue simply reflected the historic tradition, embodied in our common law, of recognizing that all medical treatment decisions ordinarily should be made by the patient, after consultation with a physician concerning the risks and benefits of treatment. Third, the holding on the privacy issue is fully consistent with the holdings of this Court in applying other abstract constitutional principles to medical treatment situations, where the Court has always respected the dignity of the individual and his or her right to obtain desired medical care. Each of these reasons independently supports the Court's holding that the decision to terminate a pregnancy implicates a fundamental right.

A. The Individual's Fundamental Privacy And Liberty Right To Be Free Of Governmental Interference Extends To Medical Treatment Decisions.

This Court has long recognized that, as part of the "liberty" protected by the Constitution's Due Process Clauses, the Constitution guarantees to each individual certain areas or zones of privacy which remain free from unjustified government interference or intrusion. See *Carey v. Population Serv. Int'l*, 431 U.S. 678, 684 (1977). The Court's privacy rulings rest on the theory that the constitutional text does not, on its face, specify all rights that warrant constitutional protection from executive or legislative intervention.[27]

The essence of the liberty interest denominated as the right to privacy is the concept that an individual in certain circumstances has a right to be let alone, *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), and that the individual must thus have "independence in making certain kinds of important decisions."

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[27] The concept of "liberty" in the Due Process Clause of the Fourteenth Amendment is a "broad" one. *Board of Regents v. Roth*, 408 U.S. 564, 572 (1972). For this reason, it has long been recognized as protecting certain personal choices. *See, e.g., Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).

Moreover, privacy is hardly the only value that has received constitutional recognition without being expressly specified in the constitutional text. For example, this Court found a right to travel in the Constitution without requiring any explicit textual basis. *Shapiro v. Thompson*, 394 U.S. 618 (1969). In addition, although "federalism" is nowhere mentioned in the Constitution, the doctrine is part of the constitutional scheme. *See Coyle v. Smith*, 221 U.S. 559, 565 (1911); *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

Whalen v. Roe, 429 U.S. 589, 599-600 (1977). As this Court has recognized, that right encompasses matters concerning marriage and procreation. The specter of governmental agents unnecessarily interfering with such inherently private, individual decisions is antithetical to basic concepts of individual liberty in a free society. See *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Loving v. Virginia*, 388 U.S. 1 (1967); *Eisenstadt v. Baird*, 405 U.S. 438 (1972). See also *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).[28]

Moreover, and of particular significance to *amici* and their members, the right to privacy which is derived from the concept of liberty also encompasses the right of an individual to make decisions about his or her medical care and treatment. As our discussion of the health implications of pregnancy and abortion makes clear, the Court's assumptions about the importance of this particular medical treatment decision are as true today as they were in 1973. Women face physiological and psychological risks and burdens when they become pregnant. Under this Court's decisions, individual choices become fundamental rights because they have a powerful and perhaps irreversible

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[28] The United States seems to accept *Griswold v. Connecticut*, 381 U.S. 479 (1965), as a legitimate decision on the ground that enforcement of a statute prohibiting the use of contraceptives would require wholly impermissible governmental prying into the private lives of individuals. (U.S. Brief at 12 n.9.) Having accepted *Griswold*, however, the government's textual theory (U.S. Brief at 23-28) for rejecting *Roe v. Wade* collapses, because this Court did not locate the right recognized in *Griswold* in a specific constitutional provision and could not, as the United States suggests, have located it in the Fourth Amendment alone. *See Carey v. Population Serv. Int'l*, 431 U.S. 678, 687 (1977). The United States' brief therefore bears "witness that the right of privacy which passes for recognition here is a legitimate one." *Griswold*, 381 U.S. at 485.

impact on who we are and who we will become. See *Fitzgerald v. Porter*, 523 F.2d 716, 719-20 (7th Cir. 1975): "These cases do not deal with the individuals' interest in protection from unwarranted public attention, comment, or exploitation. They deal, rather, with the individual's right to make certain unusually important decisions that will affect his own, or his family's destiny." Accordingly, it seems plain that the health effects of pregnancy and abortion, by themselves, should be sufficient to support the holding in *Roe* that the woman's choice should be constitutionally protected.

In holding that the abortion decision involved a fundamental right, the Court correctly noted that considerations of protecting the woman's health were vital. Specifically, the Court observed that:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved.

Roe, 410 U.S. at 153. Similarly, in explaining the basis for the protections afforded first trimester abortions, the Court identified the important health concerns implicated by the woman's choice. "[U]ntil the end of the first trimester mortality in abortion may be less than mortality in normal childbirth . . . . This means . . . that . . . the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." *Id.* at 163. See also *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 429 n.11 (1983).

The full extent of the importance attached to the pregnant woman's interest in being able to preserve her life and health is perhaps most apparent, however, in the

context of third trimester abortions. At this stage, the State's interest in protecting fetal life is considered compelling. *Roe*, 410 U.S. at 163-165. Nonetheless, this Court has recognized that protection of the pregnant woman's health interests is still considered "paramount." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986). Consequently, while *Roe* otherwise permitted proscription of third trimester abortions, it did not do so in instances where abortion "is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 163-164.

The importance of the health considerations underlying *Roe's* holdings has led this Court to observe:

> In concluding that the freedom of a woman to decide whether to terminate her pregnancy falls within the personal liberty protected by the Due Process Clause, the Court in *Wade* emphasized the fact that the woman's decision carries with it significant personal health implications--both physical and psychological. . . . [I]t could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in *Wade*.

Harris v. McRae, 448 U.S. 297, 316 (1980).

To the extent that the right in this case depends upon the importance to the woman of the consequences of her choice (see *supra* at 3-23), the decision whether or not to have an abortion should be considered a fundamental right.

B. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By The History And Traditions Of This Nation.

The Court's treatment of the woman's choice as a protected interest under the Constitution is supported by more than a common sense application of this Court's liberty and privacy rulings to the medical facts surrounding abortions. The Court's handling of the constitutional status of a medical treatment decision by the individual is also supported independently by the traditional respect this nation has always granted to the individual's interest in making personal medical treatment decisions in consultation with a physician.

The substantive guarantees afforded by the Due Process Clause encompass the protection of interests that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.). In deciding whether a particular interest is so embedded, the Court's judgment has historically been informed by whether the interest was protected at common law. The Court has stated that the liberty guaranteed by the Fourteenth Amendment encompasses "the right of the individual . . . to enjoy those privileges long recognized in common law as essential to the orderly pursuit of happiness by free men." *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923).

In this regard, it is significant that: "No right is held more sacred, [n]or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person." *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251 (1891). An individual's interest in being permitted to make personal decisions

affecting bodily security, free from government coercion, is thus a traditionally protected interest.[29]

The interest in protecting the physical security and health of one's body is an ancient one. Blackstone classified this interest as one of the three principal articles--later embodied in our Constitution as "life, liberty and property" --constituting the "rights of the people of England." "[T]he preservation of a man's health from such practices as may prejudice or annoy it . . . are rights to which every man is entitled. . . ." W. Blackstone, *Commentaries* 1:134 (1765).

Indeed, both the common and statutory law of this country have consistently recognized the importance of the individual's interest in being able freely to make decisions designed to limit risks to his or her own health. In the law of torts, this interest is reflected, for example, in the requirement of informed consent to medical treatment. The principle which supports this doctrine is that the patient has a right to weigh whatever risks attend the particular treatment and to decide if they are intolerable.

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[29] Our general tradition of protecting the individual against coerced medical decisions posing a threat to health is more relevant than the narrow history of abortion regulation for determining the fundamental rights issue before this Court. That history of abortion is misleading because restrictions on the practice arose during an era when the procedure was dangerous. As noted in *Roe*, 410 U.S. at 148-49, "when most criminal abortion laws were first enacted, the procedure was a hazardous one for women . . .[;] [a]bortion mortality was high." Even then, abortion was frequently permitted when superceding [sic] health risks were present, *e.g.*, when necessary to preserve the life of the woman. *Id.* at 138-39. However, "[m]odern medical techniques have altered this situation," as this Court recognized in *Roe*, *id.* at 149, so that abortion restrictions that once served to protect the woman's health could now jeopardize her health. *See supra* at 8-13.

> The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .'

Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (quoting *Schloendorff v. Society of New Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.)). Accord *Natanson v. Kline*, 186 Kan. 393, 410, 350 P.2d 1093, 1106, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960); F. Harper & F. James, *The Law of Torts* § 17.1 (2d ed. 1986).

Similarly, in order to guard the patient's ability to take steps essential to protecting his or her health, virtually every state in this country has recognized a physician-patient privilege. "The rationale of this privilege is to promote health by encouraging a patient to fully and freely disclose all relevant information which may assist the physician in treating the patient." *Huzjak v. United States*, 118 F.R.D. 61, 63 (N.D. Ohio 1987). See 8 J. Wigmore, *Evidence* § 2380a (McNaughton ed. 1961).

These examples illustrate this country's long-standing tradition of treating potential infringements upon an individual's ability to protect his or her health and autonomy with the utmost seriousness. That tradition is, in turn, constitutionally reflected in the Due Process Clause's substantive protection of life and liberty. "[T]he right to personal security constitutes a 'historic liberty interest' protected substantively by the Due Process Clause." *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982). Accord *Ingraham v. Wright*, 430 U.S. 651, 673 (1977) ("Among the historic liberties so protected was a right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security"). For that reason, the right to protect

one's bodily security, and to make medical decisions to that end, has always been deemed to require more than a mere minimal justification for government infringements. Under those principles, a woman's choice whether or not to terminate her pregnancy should be deemed a fundamental liberty interest protected by the Due Process Clause.

C. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By This Court's Approach To The Protection Of Health Under Specific Constitutional Provisions.

The United States criticizes (U.S. Brief at 12) the holding that a woman has a fundamental right embodied in the liberty component of the Due Process Clause to choose the medical treatment that she wishes her physician to provide as not "rooted in accepted principles." But the legal reasoning that supports the right in this context is essentially the same as the approach taken by this Court in applying other constitutional provisions, with language that is equally inexact, to issues concerning the provision of medical treatment generally. Thus, in the Fourth Amendment context, this Court has held that "our society recognizes a significantly heightened privacy interest" when government interference in medical decisions creates any increased risk to individual health. *Winston v. Lee*, 470 U.S. 753, 767 (1985).

In *Winston*, the government sought to perform a surgical procedure to remove a bullet from a criminal defendant's body. Presented with conflicting evaluations of the risk of the surgery, the court of appeals concluded that "the statistical risk of actual physical harm . . . is . . . very low [and could] be considered minimal." *Lee v. Winston*,

717 F.2d 888, 900 (4th Cir. 1983). Nonetheless, this Court reasoned:

> The operation sought will intrude substantially on respondent's protected interests. The medical risks of the operation, although apparently not extremely severe, are a subject of considerable dispute; *the very uncertainty militates against finding the operation to be "reasonable."*

Winston, 470 U.S. at 766 (emphasis supplied). The Court held that, in the absence of compelling countervailing interests, the very possibility of even marginal medical risk precluded the endangering government action. *Id.* As a matter of constitutional interpretation, the *Winston* Court's derivation of a privacy interest from the Fourth Amendment's general protection against "unreasonable searches and seizures" to protect a patient's medical treatment choice cannot be distinguished from the *Roe* Court's derivation of a privacy interest from the liberty clause to protect a conceptually identical right to make a medical treatment choice.

Similarly, the constitutional value attached to protection of personal health is also evident in this Court's decisions under the Eighth Amendment. This Court has held that the Eighth Amendment's proscription of cruel and unusual punishments is violated by "deliberate indifference to serious medical needs of prisoners." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). Thus, even an individual whose liberty interest has been constitutionally abridged retains a privacy right to receive medical care as part of the abstract protection against cruel and unusual punishment. Again, there is no basis for arguing that the process of recognizing this fundamental right of a prisoner to receive medical care is derived from anything more concrete or more settled

than the right to make an individual treatment decision which can be drawn from the Due Process Clause.

Not only is the process of analysis under these other provisions similar to what *amici* propose here for the Due Process Clause, but also the entire fabric of the Court's holdings regarding medical treatment decisions reflects a basic pattern in the Constitution which supports the right asserted in this case. See *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 259 (1974) (medical care constitutes "a basic necessity of life"). Repeated protection for a right under disparate sections of the Constitution indicates that the right is fundamental to and underlies the design of the Constitution itself. That is the case here.

The consistent close scrutiny by this Court of government attempts to interfere with personal interests in health and bodily security is not inadvertent. Rather, it demonstrates that these interests warrant the "fundamental" constitutional status that they have been granted throughout this Court's decisions. In sum, the Court should reaffirm both that there is a right of privacy generally incorporated into the "liberty" component of the Due Process Clauses and that the right extends to individual medical treatment decisions, including whether or not to terminate a pregnancy.

D. State Interference With A Fundamental Right Triggers Searching Judicial Examination Pursuant To The Compelling State Interest Test.

State "interference" with or "infringement" of a fundamental right triggers a searching judicial examination pursuant to the compelling state interest test. See *Roe v. Wade*, 410 U.S. at 155; *City of Akron*, 462 U.S. at 427. See also, *Shapiro v. Thompson*, 394 U.S. 618 (1969); *Miami Herald Publishing Co. v. Tornillo*, 418 U.S. 241

(1974). A state law which infringes a fundamental right is "presumptively unconstitutional," *Harris v. McRae*, 448 U.S. 297, 312 (1980) (quoting *Mobile v. Bolden*, 446 U.S. 55, 76 (1980)). It cannot withstand judicial scrutiny unless the state has a "compelling interest" and, in the abortion context, two elements of the compelling state interest test are met: the specific means chosen must be "reasonably related" to the state's compelling goals and thus consistent with sound medical practice; and those specific requirements must be carefully tailored to the state's purposes. Failure to satisfy either of these elements is fatal to the state's effort to infringe the woman's fundamental right. *City of Akron*, 462 U.S. at 426-31.

In much fundamental rights adjudication, a holding of infringement will doom a law because the state has no constitutionally recognized "compelling interest" in such an infringing enactment. In the abortion context, however, this Court has clearly recognized two "compelling" goals which can justify regulation of the decision whether or not to terminate a pregnancy. Thus, the state has a compelling interest in protecting the mother's health. *Roe v. Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428. Similarly, the state has a compelling interest in preserving the potential life of the fetus. *Roe v. Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428.

However, the presence of a compelling purpose does not, *ipso facto*, ensure the constitutionality of the state's particular infringement of the fundamental right. As the Court explained in *City of Akron*, 462 U.S. at 434, "the existence of a compelling state interest in health, however, is only the beginning of the inquiry." Thus, a state's requirements must be "reasonably relate[d]" to the compelling goals. *Roe v. Wade*, 410 U.S. at 163; *City of Akron*, 462 U.S. at 434 n.19 (quoting *Doe v. Bolton*, 410 U.S. 179, 194 (1973). Typically, this "reasonably related"

element of the test involves an inquiry into whether the state's requirements have a reasonable medical basis. "The State's discretion to regulate . . . does not, however, permit it to adopt abortion regulations that depart from accepted medical practice." *City of Akron*, 462 U.S. at 431. See *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 487 (1983) (Powell, J.); *Planned Parenthood v. Danforth*, 428 U.S. 52, 78-79 (1976).

Second, state laws that interfere with or burden the right must be carefully tailored to the state's objective. See *Roe v. Wade*, 410 U.S. at 165; *Planned Parenthood v. Ashcroft*, 462 U.S. at 485 n.8; *City of Akron*, 462 U.S. at 438. The law must, in other words, not be overbroad and must, therefore, advance the compelling state interest without any additional and unnecessary interference with the fundamental right. *City of Akron*, 462 U.S. at 438-439.

Application of the compelling state interest test and its elements, and the striking of any balance between fundamental rights and compelling state interests, ultimately turns, of course, on the nature of the fundamental rights that are involved. The United States, however, proposes that in determining the permissible scope of state interference with the abortion decision, under either a "compelling interest" or "undue burden" analysis, this Court should only take account of the effects of such interference on the woman's "interest in procreational choice." U.S. Brief at 22 n.16. This proposed approach is deeply flawed. It suggests that the Court should ignore the woman's fundamental interest in medical treatment decisions. Instead, abortions would be permitted only if the woman was "coerced" into becoming pregnant.

The United States' proposed analysis leaves no room for the woman to terminate a pregnancy to protect her own health or even to save her life. Obviously, denying her an

abortion at that point is wholly irrelevant to the prior decision "whether or not to beget or bear a child," U.S. Brief at 22 (quoting *Carey v. Population Serv. Int'l*, 431 U.S. 678, 685 (1977)), which the government asserts should be the only "liberty interest" at stake. But, this Court already has held that the state cannot insist that there be a "trade-off" between the life of the mother and the survival of the fetus. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768 (1986), *Colautti v. Franklin*, 439 U.S. 379, 400 (1979).[30]

It is difficult to accept that the government believes that serious threats to a woman's health or even her life are not relevant in assessing the balance between the woman's right and the state's interests. The manifest shortsightedness of the government's reasoning undermines completely its proposed approach. In our view, it would be inconsistent with any reasonable notion of a "narrowly tailored" statute to hold that, in order to protect its interest in potential life, a state may, regardless of circumstances and irrespective of the severity of the threat to the woman's life or health, flatly prohibit all women from choosing, in consultation with their physicians, to have an abortion performed.

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[30] The direct one-to-one trade-off is what distinguishes this case from *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). It is one thing to hold that the state can compel an individual to face a limited health risk in order to protect a significant number of other individuals and where even the specific individual's health is placed at significant risk if he or she is allowed to "opt out." It is fundamentally different to say that society can impose a direct and immediate burden and risk on one individual in order to benefit another.

II. SECTIONS 188.029 AND 188.205 OF THE MISSOURI STATUTE UNCONSTITUTIONALLY INFRINGE THE FUNDAMENTAL RIGHT OF PATIENTS TO MAKE MEDICAL DECISIONS IN CONSULTATION WITH THEIR PHYSICIANS.

Given the fundamental nature of the woman's right in being able to decide whether to terminate a pregnancy, there are two types of state action which trigger heightened judicial scrutiny. First, heightened scrutiny is required when state laws interfere with the *woman's* decisions whether to enter into a physician-patient relationship with respect to abortion and whether or not to terminate her pregnancy. This Court has recognized specific situations when the compelling interest test should be applied: when a state abortion law imposes certain additional health risks on the woman; when a state law attempts to influence the woman's informed choice between abortion or childbirth through the physician-patient relationship; or when a state law imposes costs on a woman unique to the abortion procedure and out of proportion to any health benefits.[31]

Second, heightened scrutiny is appropriate when state laws interfere with a *physician's* ability to enter into a physician-patient relationship, to counsel the patient and to provide medically indicated care and treatment pertaining to the patient's pregnancy termination decision. Thus, there is infringement when a state law interferes with a physician's best medical judgment or is otherwise inconsistent with the state of medical knowledge and sound

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[31] *See, e.g., Harris v. McRae*, 448 U.S. at 328 (White, J., concurring) (additional health risks); *City of Akron*, 462 U.S. at 444 (influence woman's choice); *Planned Parenthood v. Danforth*, 428 U.S. at 69 (share decision-making authority); and *City of Akron*, 462 U.S. at 435, 438, 447 (costs unique to abortion).

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1988

No. 88-605

WILLIAM L. WEBSTER, et al.,
Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, et al.,
Appellees.

On Appeal from the United States Court of Appeals For the Eighth Circuit

BRIEF FOR BIOETHICISTS FOR PRIVACY AS AMICUS CURIAE SUPPORTING APPELLEES

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EXHIBIT B

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BRIEF FOR BIOETHICISTS FOR PRIVACY AS AMICUS CURIAE SUPPORTING APPELLEES

Interest of Amicus

Amicus is an ad hoc group of 57 philosophers, theologians, attorneys, and physicians from 20 states and the District of Columbia who teach medical ethics to medical students and/or physicians, or who have a major professional interest in medical ethics. Although the precise beliefs and practices of the members of this group vary, as do their professional and religious backgrounds, the members believe that permitting competent adults to make important, personal medical decisions in consultation with their physician is a fundamental principle of medical ethics, and that the doctor-patient relationship deserves the constitutional protection this Court has afforded it under the right of privacy. Medical ethics, individual autonomy, and professional accountability will all be fostered by preserv-

ing the right of privacy. Compromising the right of privacy, and substituting the state as the decisionmaker in the doctor-patient relationship, would undermine principles of medical ethics and compromise principles of good patient care and good medical practice to the detriment of physicians and patients alike.

Summary of Argument

I

Missouri asks this Court to renounce a right of privacy which this Court has described as "older than the Bill of Rights." This Court has provided lawmakers with a consistent and coherent set of parameters for identifying what the right of privacy protects, especially with respect to decisions about abortion. Abandonment of the right of privacy would permit state legislatures to control personal decisions that are now made in the doctor-patient relationship. Without the protection of the right of privacy, each legislature would be free to impose its values by dictating the outcome of what are and should be personal medical care decisions.

II

A. As this Court has recognized, a woman's right to decide to terminate a pregnancy is exercised within the context of the doctor-patient relationship. The ancient tradition of safeguarding the privacy and freedom of unfettered communication between doctor and patient is embodied in ethical precepts which the law recognizes and supports. The Missouri legislation is a direct, governmental attack on this relationship, thereby jeopardizing patients' rights, and compromising physicians' ethical obligations to their patients.

B. Both legal and ethical principles require physicians to discuss health risks that are caused or exacerbated by pregnancy and information concerning possible fetal genetic

or congenital disorders. The Missouri statutes prohibit such discussions by publicly-funded physicians if they may lead to a decision to abort. Physicians' speech is censored and patients are deprived by the state of critical information on which to base decisions about pregnancy. The ethical practice of medicine is made unlawful and the health and well-being of pregnant patients is likely to be seriously jeopardized as a result. Missouri gives "any taxpayer" of the state standing to enforce its restrictions in the courts. Thus, whatever is said or done in the privacy of the doctor-patient relationship is subject to public scrutiny at any time.

C. Without the constitutional right of privacy, there would be no constitutional principle that would prevent a state from prohibiting patients from using *any* medically recognized and accepted treatments which a majority of legislature happens to disfavor. Worse, a state would be free to prevent physicians from even telling their patients about such treatment. This differs dramatically from a state's merely refusing to pay for certain treatments.

Advances in medical science have made possible new methods of treatment for a wide variety of medical conditions, often controversial, and with the potential for profound consequences for the patient. Scientific progress has increased the importance of the doctor-patient relationship, for it is only in this context that difficult personal medical decisions can be made taking into consideration all of the medical and personal consequences that may ensue. Thus there is even more reason today to uphold the constitutional protection of decisions made in the privacy of the doctor-patient relationship than when *Roe v. Wade* was decided. For these reasons the decision of the court of appeals should be affirmed.

Argument

I. THE CONSTITUTIONAL RIGHT OF PRIVACY WHICH PROTECTS THE RIGHT TO MAKE PERSONAL MEDICAL DECISIONS IS A FUNDAMENTAL RIGHT AND A CENTRAL AMERICAN VALUE WHICH IS "IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY" AND THE COURT SHOULD CONTINUE TO PROTECT IT.

In *Griswold v. Connecticut*, 381 U.S. 479 (1965), this Court, in striking down a state statute forbidding married couples from using contraceptives, stated, "We deal with a right of privacy older than the Bill of Rights--older than our political parties, older than our school system." *Id.* at 486. In explaining this fundamental constitutional right of privacy, the Court recognized that there are decisions that are so personal, so private, and that so profoundly affect the individuals who must live with the consequences, that the state has no power to interfere in those decisions, absent a compelling interest. Since *Griswold*, this Court has applied the right of privacy to protect an unmarried person's right to decide "whether to bear or beget a child," *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972), and decisions whether or not to terminate a pregnancy. *Roe v. Wade*, 410 U.S. 113 (1973).

When the State of Missouri and the United States as amicus curiae ask this Court to overrule *Roe v. Wade*, they are asking that the most private decision that can be made by any individual be removed from that affected individual and turned over to a state legislature. We respectfully submit that this Court should not take such action.

In *Griswold* this Court recognized that the private relationship between a husband and wife prevented the state from intruding on their contraceptive decisions. In *Roe* the Court recognized the privacy of the doctor-patient relationship. While *Roe* further defined a woman's right to make

reproductive decisions, it also recognized that the pregnant woman required the advice and counsel of a licensed physician. Thus, in *Roe* the Court concluded that during the first trimester "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." 410 U.S. at 163. Later the Court stated that during the first trimester "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Id.* at 164. The Court also pointed out that its decision "vindicates the right of the physician to administer medical treatment according to his professional judgment" up until the point that compelling state interests justify intervention. *Id.* at 165-66. Finally, the Court pointed out that the abortion decision is 'inherently, and primarily, a medical decision" for which "basic responsibility" rests with the physician. *Id.* at 166.

Thus, as *Griswold* protected the privacy of the marital relationship, *Roe* protected the privacy of the physician-patient relationship. "The right of privacy has no more conspicuous place than in the physician-patient relationship . . ." *Doe v. Bolton*, 410 U.S. 179, 219 (1973) (Douglas, J., concurring). In this relationship both the physician and the pregnant woman must agree that termination of pregnancy is appropriate in order to have this medical procedure performed. Whether abortion is an appropriate option for a *particular* patient is, by definition, a decision that must be made by the doctor and the patient in each case. It is the right to make particularized personal decisions that is at the core of *Roe* and its progeny, and it

is this right that Missouri and the United States desire to destroy.[1]

In *Doe v. Bolton*, the court found that the restrictions Georgia had placed on abortion violated both the patient's and physician's freedom. For example, Georgia's requirement that two licensed physicians must agree with a woman's personal physician's judgment that an abortion is appropriate, and that a hospital committee of at least three other doctors must concur in the abortion decision violated the privacy protection of both the doctor and patient. In the Court's words, "The woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it are substantially limited by this statutorily imposed overview." 410 U.S. at 197.

Since *Roe* this Court has reviewed a large body of legislation designed to deny patients and physicians their right to make personal and professional judgments about how best to deal with a patient's pregnancy. As even the United States concedes, "Roe and its progeny have resolved most of the central questions about the permissible scope of abortion regulation. . . ." Brief for the United States as Amicus Curiae Supporting Appellants at 21, n. 15. Through sixteen years of constitutional adjudication this Court has provided lawmakers with a consistent and

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[1] Justice Douglas, concurring in *Doe v. Bolton*, 410 U.S. at 211, described the right of privacy as "*freedom of choice in the basic decisions of one's life respecting marriage, divorce, procreation, contraception, and the education and upbringing of children.*" He also thought of it as "*freedom to care for one's health and person, [and] freedom from bodily restraint or compulsion . . .*" *Id.* at 213.

coherent set of constitutional guidelines in this area.[2] Laws that recognized and protected the physician-patient relationship have been upheld, and laws designed to weaken or destroy that decision-making unit have been struck down. Thus, in *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52 (1976), the Court readily upheld a general informed consent provision, even as it applied to the first trimester, because not only did it not burden the abortion decision, it enhanced the physician-patient relationship. On the other hand, the Court has struck down a provision requiring physicians to recite a "parade of horribles" because it intruded "upon the discretion of the pregnant woman's physician." *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 445 (1983). Under this statute every physician was made an agent of the state who was required to recite the state's anti-abortion message

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[2] A review of the Court's abortion decisions indicate that it has used the following "tests" in various combinations to evaluate the constitutionality of abortion statutes:

1. Has the state placed an obstacle in front of the woman or otherwise significantly burdened the pregnant woman's ability to choose or obtain an abortion?
2. Is abortion being treated differently from other similar medical or surgical procedures?
3. Does the regulation interfere with the treating physician's exercise of professional judgment?
4. Does the regulation conflict with, or is it stricter than, accepted medical and scientific norms?
5. Is the regulation designed to protect maternal health where no less intrusive or less expensive alternative will do?
6. If a postviability rule, does the regulation protect the fetus without putting the mother in jeopardy?

Annas, *Webster and the Politics of Abortion*, 19 Hastings Center Report 36 (March/April 1989), citing Glantz, "Abortion: A Decade of Decisions," in *Genetics and the Law III* 305 (A. Milunsky & G. Annas, eds. 1985).

to every patient, regardless of her individual need or desire.

A similar statute was involved in this Court's most recent case on abortion law. The Court reiterated that forcing a physician to provide prescribed information "makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 763 (1986). The Court summarized the situation aptly: "All this is, or comes close to being, state medicine imposed upon the woman, not the professional medical guidance she seeks, and it officially structures--as it obviously was intended to do--the dialogue between the woman and her physician." *Id.*

The controversy that ranges over abortion is not resolvable through reason, logic, or majority vote. It is an emotional issue governed by one's background, religious upbringing, and moral beliefs. The post-*Roe* state statutes were not health or safety laws, but rather means to control physicians and their patients so that a particular legislature's philosophical position could be imposed on pregnant women and their physicians. The Court in *Roe* recognized this problem when it pointed out that there is great diversity of opinion among philosophers, theologians and scientists about when life begins. It further recognized that the judiciary is certainly in no position to resolve this issue. 410 U.S. at 159. This is equally true of legislatures. As a result, the Court concluded that "we do not agree that, by adopting one theory of life Texas may override the rights of the pregnant woman that are at stake." *Id.* at 162.

Justice Stevens, concurring in *Thornburgh*, made a similar point: "In a sense, the basic question is whether

the 'abortion decision' should be made by the individual or by the majority 'in the unrestrained imposition of its own, extraconstitutional value preferences.'" 476 U.S. at 777-78. That is also the issue posed in this case. Justice Stevens was correct in pointing out that without the safeguards in *Roe*, there is essentially no way to restrain what the state may do in imposing its value judgments on the individual:

> . . . if federal judges must allow the State to make the abortion decision, presumably the State is free to decide that a woman may *never* abort, may *sometimes* abort, or as in the People's Republic of China, must *always* abort if her family is already too large. In contrast, our cases represent a consistent view that the individual is primarily responsible for reproductive decisions, whether the state seeks to prohibit reproduction or to require it.

Id. at 778, n. 6 (emphasis in original, citations omitted).

The pre-*Roe* world to which Missouri and the United States would like us to return is a world in which the State would have essentially absolute discretion to permit or outlaw abortions. Thus, women who were pregnant as a result of rape could be required to maintain their pregnancies and be forced to go through labor and delivery with the rapist's unwanted child. Women who would become blind, paralyzed or suffer other grave injury as a result of the continuation of their pregnancy could be compelled by state legislatures to suffer such harm. Parents who, as a result of genetic counseling and testing, know that their child will be born with a genetic disease that will cause it to die a slow, painful death, could be required to carry that pregnancy to term. These examples are not based on wild speculation about what the state of the law *might* be if *Roe* were overruled--it is based on what the state of the law

actually was at the time of *Roe*. Prior to *Roe*, abortions were outlawed in a majority of states unless the *life* (not health) of the pregnant woman was jeopardized by the continuation of the pregnancy. *Roe*, 410 U.S. at 118.[3]

The abortion cases are not just about abortion, but about the very basis of what it means to be a free person in a free society.[4] If the state can make reproductive decisions on behalf of any individual, what decision is it precluded from making? If legislatures are allowed to impose without restraint value judgments that deeply and directly affect individual citizens, what is left of personal freedom? Without the right of privacy, what constitutional principle would prevent states from reimposing restrictions on contraceptive distribution and use, since unfertilized ova constitute *potential* human life? *Doe v. Bolton*, 410 U.S. at 217 (Douglas, J. concurring). Indeed, since both Missouri and the United States argue that the state should

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[3] In its brief, the United States readily admits that states have passed "inflammatory" abortion statutes since *Roe* was decided. Brief for the United States as Amicus Curiae Supporting Appellants at 21, n.15. What is remarkable is that the United States blames the existence of *Roe* for the "inflammatory" nature of these statutes, rather than legislators' hostility to the right of pregnant women and their physicians to make decisions concerning termination of pregnancy. Should *Roe* be overruled, the tendency of legislatures to pass such inflammatory statutes will continue. What will be absent is the constitutional protection from such legislative excesses.

[4] In *Whalen v. Roe*, 429 U.S. 589, 599-600 (1977), the Court noted that the constitutional right of privacy protects an individual's "interest in independence in making certain kinds of important decisions." In that case the Court upheld a New York statute requiring physicians to report to a state agency the prescription of certain controlled substances, because under the statute "the decision to prescribe, or to use, is left entirely to the physician and the patient." *Id.* at 603.

be free to determine when life begins, a state could choose any point in time it pleases-conception, live birth, the time the ovum develops, or three years of age.[5] Since there is no scientific answer to this question, any value judgment on this point is as "rational" as any other. However, just as this Court found that "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority," *Planned Parenthood v. Danforth*, 428 U.S. at 74, it should also conclude that one's constitutional rights are not destroyed magically because of an arbitrarily state-defined point at which "life begins."

The problem with providing the state with the essentially unlimited power sought by Missouri and the United States is that the state's actions have such a potentially profound impact on the lives of citizens. It must be kept in mind that the State is attempting to impose its values on individual citizens in order to control their decisional rights. Under *Roe* no one's values are imposed on anyone else; people are free to make the decisions that they believe are best for themselves. As Justice Stevens put it,

> In the final analysis, the holding in *Roe v. Wade* presumes that it is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny. Arguably a very primitive society would have been protected from evil by a rule against eating apples; a majority familiar with Adam's

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[5] *See*, Brief for The New England Christian Council as Amicus Curiae at 12. Therein is described an effort to place on the ballot in Massachusetts the following referendum question: "In *Biological Terms*, when does an individual human life begin?" The choices the voters could check off included "A. Conception" "B. Viability" "C. Birth" "D. Write In - specify a different term___."

> experience might favor such a rule. But the lawmakers who placed a special premium on the protection of individual liberty have recognized that certain values are more important than the will of a transient majority.

Thornburgh, 476 U.S. at 781-82 (concurring opinion).

II. The Right Of Privacy Protects The Rights Of Individuals To Make Personal Medical Decisions In A Doctor-Patient Relationship

A. *The Doctor-Patient Relationship, not the Legislature, is the Proper Locus for Medical Care Decisions*

The central question before the Court is whether personal medical care decisions should be made by patients and their physicians, or by the state. The doctor-patient relationship is highly valued in our society.[6] The importance of the doctor-patient relationship to individual citizens increases in proportion to advances in medical science. These advances have made the consequences of many medical interventions increasingly dramatic in the lives and deaths of individual citizens and their families. The importance of who makes the treatment decision increases as the complexity of the options and the severity of the impact of treatment on the individual patient increases. *Roe* properly took full account of changing medical science. The central premise of *Roe* and *Doe*, that inherently personal medical decisions, including those

[6] Indeed, protecting the ethical integrity of the medical profession in ways consistent with the individual autonomy of patients has been deemed a "compelling state interest" by courts since *Roe v. Wade*. *E.g.*, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

involving abortion, should be made in the context of a doctor-patient relationship protected from governmental dictates, remains sound jurisprudence.

The doctor-patient relationship has been a privileged and protected one throughout the history of Western civilization. Plato, for example, describes how in Ancient Greece slaves were treated as objects and that therefore no conversation between them and the physician occurred. The relationship between a free physician and a free citizen, by contrast, fit what it means to be a free person; that is, physicians talked to their patients:

> The free practitioner who, for the most part, attends free men, treats their disease by going into things thoroughly from the beginning in a scientific way, and takes the patient and his family into his confidence . . . He does not give his prescriptions until he has won the patient's support . . .

Laws, 4.720b-e.

The doctor-patient relationship between two free citizens that has become the cornerstone of Western medical ethics begins with an individual who determines that a condition requires medical attention. Medical attention is voluntarily sought, and the physician makes a decision as to whether or not medical care can be of benefit to the patient, and if so, recommends one or more alternatives. The doctor and patient then discuss these alternatives. Together they decide what course of action to pursue based on their perceptions of benefit in a private, confidential relationship which ethical principles of

autonomy, beneficence and justice have structured and the law has fostered and protected.[7]

The decision to continue or terminate a pregnancy is just one example albeit a dramatic one, of important, personal medical decisions made in this relationship. To insure that a mutually-acceptable decision is arrived at with full understanding, the common law has required physicians to share information with their patients under the doctrine of "informed consent."[8] Law and ethics, therefore, have now effectively merged. As the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research concluded,

> Although the informed consent doctrine has substantial foundations in law, it is essentially an ethical imperative. . . . Ethically valid consent is a process of shared decisionmaking based upon mutual respect and participation . . . adults are entitled to accept or reject health care interventions on the basis of their own personal values in furtherance of their own personal goals.

Making Health Care Decisions 2-3 (1982).

B. *States Should Not be Permitted to Dictate or Censor the Content of Discussions that Occur in a Doctor-Patient Relationship*

It is in the informed consent context, and its respect both for the rights of individual patients and the integrity

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[7] *See, e.g.*, Ad Hoc Committee on Medical Ethics, American College of Physicians, *American College of Physicians Ethics Manual*, Part I, 101 Annals of Internal Medicine 129, 130 (1984).

[8] Legal action to remedy instances of nondisclosure developed where the Platonic ideal was not being followed and physicians were withholding important information from their patients. R. Faden & T. Beauchamp, *A History and Theory of Informed Consent* (1986).

of the medical profession, that *Roe's* placement of the abortion decision with "the woman and her physician" is properly understood. Neither party has total or arbitrary power, but both must agree and consider the decision appropriate and reasonable before it can be acted on. *Roe* properly assumed that "states would subject the woman's wishes to interpersonal testing within a clinical relationship, by treating abortion as a medical procedure . . . A medical decision, at its best, is made between a patient and a doctor who acts pursuant to professional values, ones developed out of clinical encounters and subjected to peer criticism within a regimen of professional education, research, and ethical study." R. Goldstein, *Mother-Love and Abortion: A Legal Interpretation* 81 (1988); *see also* A. Jonsen, M. Siegler & W. Winslade, *Clinical Ethics* 62 (2d ed. 1986).

Of course, such an interpersonal dialogue can only take place in an atmosphere in which the physician is free to exercise his or her best professional judgment and discuss with a patient all of the information, including treatment options, relevant to the patient's decision. Section 188.205 of the Missouri statute before this Court, however, would prohibit such dialogue. That section makes it "unlawful for any public funds to be expended . . . for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life." The term "encourage or counsel" is so vague that reasonable people would be unable to distinguish between lawful and unlawful behavior. It does not merely prohibit coercing a woman to have an abortion. Rather, the state uses words that describe the personal discussions between a woman and her physician about the management of her pregnancy. Other

courts have agreed that this language prohibits physicians from talking to their patients.[9]

In section 188.210, Missouri attempted to make it "unlawful" for a publicly-employed physician or other health care personnel to "counsel or encourage a woman to have an abortion not necessary to save her life." In this appeal, Missouri has abandoned any defense of this direct prohibition against counseling of patients by physicians. Instead Missouri seeks to achieve the same result by a different means in section 188.205. This section certainly prohibits any publicly-employed physician from counseling or encouraging abortions because it is unlawful to expend public funds for that purpose, and the physician's salary is derived from state funds. Thus, its impact is identical with the second sentence of section 188.210. In fact this section has an even wider impact than 188.210 because it applies not just to public employees, but to anyone who receives state funds.

The statute both silences physicians and forces patients to remain ignorant, erecting a state-created barrier between a woman and her physician. Under the stature [sic], for example, a physician, public or private, who receives state funds would be unable to honestly respond to a pregnant

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[9] Two federal district courts found that the Department of Health and Human Services regulations prohibiting family planning programs funded under Title X from counseling or referring for abortion, 53 Fed. Reg. 2922 (Feb. 2, 1988), violated the First Amendment rights of the programs and enjoined their enforcement. *Massachusetts v. Bowen*, 679 F. Supp. 137 (D. Mass. 1988), appeal docketed, No. 88-1279 (1st Cir. Mar. 24, 1988); *Planned Parenthood Federation v. Bowen*, 680 F. Supp. 1465 (D. Colo. 1988). A third district court agreed that the prohibition forbade speech but concluded (erroneously we believe) that granting Title X funds to support one idea and not another did not infringe free speech. *State of New York v. Bowen*, 690 F. Supp. 1261 (S.D.N.Y. 1988), *aff'd.*, 863 F.2d 46 (2d Cir. 1988).

woman whose health is endangered by the pregnancy when she asks, "Doctor, what do you think I should do?", if the honest answer were, "I would recommend you have an abortion."[10]

Prohibiting physicians who receive state funds from "encouraging or counseling" pregnant women consistent with their best medical judgment is contrary to good medical practice and jeopardizes patients' rights. Information concerning health risks that are caused or exacerbated by pregnancy and information concerning possible fetal genetic or congenital disorders are squarely among the categories of information that a physician is obligated by law and ethics to disclose to a pregnant woman in order to facilitate knowledgeable decisions about managing her pregnancy.[11] It is good and accepted medical practice to

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[10] An analogous "gag rule" is apparently in effect in the Soviet Union in the area surrounding Chernobyl where it is reported that government authorities assure everyone that all is normal, "and then advise villagers not to bear children or each locally grown mushrooms." When the villagers take their children to special government clinics in Kiev for regular medical tests, "the doctors refuse to disclose the results." Gumbel, *Villagers Suffering Chernobyl's Fallout Face Soviet Silence*, Wall Street J., March 6, 1989, at 1, col. 4.

[11] The Federal Food and Drug Administration itself requires manufacturers of intrauterine devices to inform physicians that if a woman becomes pregnant with an I.U.D. in place, and removal of the I.U.D. is difficult, "termination of the pregnancy should be considered and offered the patient as an option..." 21 C.F.R. 310.502(b)(1). The physician's counseling obligation includes informing parents of the availability of prenatal diagnosis of genetic abnormalities. *E.g., Goldberg v. Ruskin*, 128 Ill. App. 3d 1029, 471 N.E.2d 530 (1984), *aff'd*, 113 Ill. 2d 482, 499 N.E. 2d 406 (1986) (failure to advise parents of tests designed to detect Tay-Sachs disease). Physicians also have an obligation to diagnose abnormalities with due care and disclose their findings. *E.g., Smith v. Cote*, 128 N.H. 231, 513 A.2d 341

inquire into the genetic and medical history of a prospective mother and father who consult any physician for advice or care concerning family planning, contraception, and pregnancy evaluation. *See* American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 18-19 (5th ed. 1985); S. Elias and G.J. Annas, *Reproductive Genetics and the Law* (1987); President's Commission for the Study of Ethical Problems in Medicine, *Screening and Counseling for Genetic Conditions* 23-31 (1983).

By attempting to silence certain physicians, Missouri seeks to prevent them from performing their ethical and legal obligations to their patients consistent with existing medical science, and thereby deprive patients of information they need in order to decide whether to have a child. In this regard the state of Missouri promotes ignorance, viewing an uninformed patient as a desirable result. There are medical conditions for which abortion is one of the reasonable medical procedures that should be discussed. For example, Tay-Sachs disease is a genetic disorder that occurs in one in four pregnancies when both husband and wife are carriers of the gene. The disease "is characterized by motor weakness, usually beginning between 3 and 6 months of age. . . deafness, blindness, convulsions, and generalized spasticity are usually in evidence by 18 months of age . . . the child develops a state of decerebrate rigidity, with death usually resulting . . . by 3 years of

(1986) (failure to timely diagnose rubella and inform parents of consequences). So strongly have courts insisted on counseling, that they have held physicians liable for failing to offer information which might lead a patient to consider abortion even when abortion was statutorily proscribed in most states. *See e.g., Jacobs v. Theimer*, 519 S.W.2d 846 (Tex. 1975) (physician's failure to diagnose rubella in pregnant woman in 1958 and to advise her of risks to fetus held actionable wrong even though abortion was illegal in Texas).

age. No specific therapy for Tay-Sachs disease is available." S. Elias & G. Annas, *Reproductive Genetics and the Law* 63 (1987) and sources cited therein. Since abortion is the *only* way to prevent this tragedy, a physician who informs a couple of the existence of prenatal testing to detect it, and discusses the option of abortion with them would be violating the proscription against "counseling or encouraging" abortion. Without the option of prenatal screening, many at risk couples would simply choose to abort all pregnancies. "In fact, since more than 95% of all prenatal diagnostic tests are negative, the overwhelming majority of such testing helps lead to the birth of children that might not otherwise have been born." *Id.* at 83. Thus the irony is that any law that inhibits physicians from counseling pregnant women about the availability of genetic testing and the option of abortion may actually increase the number of abortions performed.

Since section 188.210 prohibits publicly-employed physicians from *performing* abortions, it is essential that they be permitted to refer a patient in need of abortion to a physician who is willing and able to do so. Yet, such a medically appropriate referral would violate the proscription against encouraging and counseling, since abortion is a probable outcome of the referral. At the same time, failure to refer the patient to the second physician would be negligent medical practice which could harm the patient.[12]

[12] *See, e.g., Jewson v. Mayo Clinic*, 691 F.2d 405 (8th Cir. 1982). If a physician determines, in the exercise of sound clinical judgment, that the pregnancy poses a threat to the health or well-being of his patient, he is not excused from disclosing that judgment simply because he may be unable to perform an abortion. If he is unwilling or unable to perform an abortion that he believes is medically indicated, he must also disclose that fact to the patient. *Manion v. Tweedy*, 257 Minn. 59, 100 N.W.2d 124, 128 (1959). In addition, the physician must immediately refer the patient to an appropriate provider, because

The fact that the physicians currently targeted by the Missouri statute are paid with state funds does not lessen either the extent of the invasion or the obligation such physicians have to counsel their patients.[13] Government-employed physicians who were not expected or obliged to render ongoing care to individuals have been found to owe a duty of disclosure to persons they examine. For example, in *Betesh v. United States*, 400 F. Supp. 238 (D.D.C. 1974), a selective service physician was found liable for failing to disclose a chest abnormality in a recruit during a pre-induction physical. The recruit later died of Hodgkins disease, which might have been successfully treated had treatment begun when the abnormality was first discovered. Even in the absence of a consensual doctor-patient relationship, concealment of the information was actionable, the court found, because "the Government physicians were under a duty to act carefully, not merely in the conduct of the examination, but also in subsequent communications to the examinee." *Id.* at 246. Thus, the legal and ethical obligation to counsel does not depend upon the nature of the physician's employer or source of payment.

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delay could cause harm and make further treatment, including later termination of pregnancy, more risky and harmful. *See, e.g., Steele v. United States*, 463 F. Supp. 321, 330 (D. Alaska 1977); *Wells v. Billars*, 391 N.W.2d 668 (S.D. 1986).

[13] The source of payment does not excuse a physician from fulfilling his obligations to his patient. As the California Appeals Court said in *Wickline v. California*, 192 Cal. App. 3d 1630, 1645, 228 Cal. Rptr. 661 (1986), *app. dism'd*, 239 Cal. Rptr. 805, 741 P.2d 613 (1987): "[T]he physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for his patient's care."

The Missouri legislation not only interferes with honesty on the party of the physician, it does so in the most intrusive fashion, sundering the curtain of privacy from the physician-patient relationship. Not only does the state claim the right to control what doctors say to patients, it encourages strangers to police what is said. Section 188.220 of the Missouri statute grants standing to "any taxpayer of [the] state" to enforce the provisions which prohibit encouraging or counseling a woman to have an abortion. Thus, perfect strangers are given the power of private attorneys general to scrutinize the highly personal information discussed in a physician's office. The statute can only be enforced by requiring physicians and their patients to publicly disclose the content of their discussions held in the privacy of the doctor-patient relationship. Having strangers invade this relationship is every bit as offensive and chilling as permitting "police to search the sacred precincts . . . of marital bedrooms." *Griswold v. Connecticut*, 381 U.S. at 485.[14]

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[14] A recent New York case underscores the inappropriateness of encouraging strangers to intervene in these private decisions. The case, *In the Matter of Martin Klein*, Supreme Ct. of New York, Nassau Cty. No. 1736/89 (Feb. 7, 1989), involved a 32-year-old woman who was 17 weeks pregnant, and comatose as a result of an automobile accident. Her husband was advised by her physician that continuation of her pregnancy presented a serious threat to her life, and that termination of the pregnancy was indicated. He then petitioned the court for an order that he be appointed his wife's temporary guardian for the purpose of authorizing her physician to perform such medical procedures, including abortion, as may be necessary to preserve her life. Two total strangers with an anti-abortion agenda petitioned the court requesting to be made the guardian of the woman and the non-viable fetus, in an attempt to exclude the patient's husband and parents from making these decisions. Both trial court and Appellate Division decided for the husband. As the Appellate Division stated, "these absolute strangers to the Klein family, whatever their motivations, have no place in the

C. *Overruling the Constitutional Right of Privacy Would Seriously Undermine Individual Autonomy and Would Permit the State To Make Medical Care Decisions That Belong to Individuals*

A consistent series of decisions since *Roe v. Wade* permit individuals to refuse various medical interventions. Many of these decisions are based in part on the constitutional right of privacy which enables individuals to make important personal medical decisions for themselves. In a widely cited case, for example, the New Jersey Supreme Court decided that, were she competent, Karen Ann Quinlan, a young woman in a permanent coma, would have the authority under the constitutional right of privacy to decide to have the mechanical ventilator that sustained her life removed. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, 663 (1976), *cert. den. sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). Since she was incompetent, the court ruled that her parents could act in her behalf. In *Quinlan*, as in many similar cases decided since, the state argued that it, not the patient, should make the decision whether or not to employ an intrusive, and often futile, medical intervention.

Without the shield of the constitutional right of privacy, citizens would have no protection from such state interventions in private medical matters, because states would be free to legislate virtually any restrictions on individual treatment decisions that even a bare majority of legislators wished. This is particularly important today when new forms of medical treatment and knowledge require patients to make controversial choices. Since 1973, physicians have learned to fertilize human eggs in a petri

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midst of this family tragedy." *Matter of Nancy Klein*, New York Appellate Division, Second Department, New York Law Journal, Feb. 14, 1989, at 21.

dish and transfer the resulting embryo to the wife for gestation; to accurately detect severe fetal handicaps such as anencephaly and neural tube defects; and to maintain patients who cannot breathe on their own in a permanent coma for months and even years.

It would not be far-fetched to hypothesize a state that would choose to outlaw the use of *all* prenatal diagnostic techniques by both public and private physicians. Legislators may feel that such tests lead couples either not to have children or to abort their pregnancies. Without the protection of the constitutional right of privacy, state legislatures would be empowered to control the knowledge and use of such medical techniques, and require couples to make their child-bearing decisions in ignorance.[15] What would prohibit states from outlawing new and "unnatural" means of conceiving a child such as *in vitro* fertilization techniques? What would prohibit states from requiring that *every* medical intervention must be used to keep a dying person alive as long a biologically possible, regardless of the desires of the patient or family, and no matter that the patient's physician agrees that this would not be good medical practice? No constitutional principle, other than the right of privacy, would protect these decisions, and others like them, from being made for patients by the state. Unfettered by the constitutional right of privacy, states

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[15] Prohibitions against *payment* for treatment should not be confused with prohibitions against providing *information* about treatment. For example, the state of New Hampshire has the right not to pay for bone marrow transplants, as evidenced by its initial decision in the case of a six-year-old boy in February 1989. Hohler, *State Policy, Human Tragedy*, Boston Globe, Feb. 26, 1989, at 1. It would be astonishing, however, to even suggest that New Hampshire should be able to forbid the boy's physician, even if the physician were a state employee, from telling him that he needed a transplant and could get it elsewhere. Yet this is what Missouri claims it may do.

would have virtually unlimited power both to prohibit citizens from obtaining basic medical care from their physicians, and to require them to undergo medical procedures against their will.

We have already witnessed examples of how state power can be misused in a way that increases the suffering of its citizens when the right to make personal medical decisions is not treated as a fundamental constitutional right. In one example, a competent pregnant woman who was dying of cancer was forced to endure a cesarean section against her will, and that of her family and physicians, by a judge who thought that the state's interest in potential fetal life outweighed any interest she might have in refusing surgical intervention. *In re A.C.*, 533 A.2d 611 (App. D.C. 1987), *vacated* 539 A.2d 203 (App. D.C. 1988).[16] After the forced surgery--which was, in

[16] There are at least twenty-one orders by lower court judges that have required competent adult women to undergo cesarean section operations (a major surgical procedure which is substantially more life-threatening than abortion) instead of the normal delivery that they wished to have. Kolder, Gallagher & Parsons, *Court-Ordered Obstetrical Interventions*, 316 New Eng. J. Med. 1192 (1987). These orders were based on the notion that the state, through its judges, has a greater interest in the potential life of the fetus and the method of childbirth than the woman herself, and demeaned and dehumanized the pregnant woman by denying her the right to voluntarily choose the method of childbirth. Continued discussion with her physician, rather than hasty resort to emergency decisions by judges, is properly encouraged by recognizing the right to privacy in the doctor-patient relationship. Indeed, "By protecting the liberty of the pregnant patient and the integrity of the voluntary doctor-patient relationship, we not only promote autonomy; we also promote the well-being of the vast majority of fetuses." Annas, *Protecting the Liberty of Pregnant Patients*, 316 New Eng. J. Med. 1213, 1214 (1987). *And see* T. Engelhardt, *The Foundations of Bioethics* 224-27 (1985); and Nelson & Milliken, *Compelled Medical Treatment of Pregnant Women*, 259 J.A.M.A. 1060 (1988).

effect, a forced abortion of a non-viable fetus--both mother and child died.

In a second example, with facts virtually identical to those in *Quinlan*, a Missouri trial court found that it had sufficient evidence, based on the patient's prior statements and her family's testimony, that the patient would not wish to receive treatment if she were in a permanent coma, and ruled that treatment should therefore be stopped in accordance with her "constitutionally guaranteed liberty." *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988). The Missouri Supreme Court overruled the trial court's finding and, disregarding the patient's previous statements and her parent's wishes, turned over her medical treatment decisions to employees of the state. This means that for the rest of her life the people who know and love her most are relegated to the role of passive observers. *See*, generally, Annas, *The Insane Root Takes Reason Prisoner*, 19 Hastings Center Report 29 (Jan./Feb. 1989). The Missouri Supreme Court's decision was based in part on its reading of the preamble of the abortion statute at issue in this case.

These examples demonstrate that state interference is not hypothetical. State medical treatment decisions are at best arbitrary and impersonal, and at worst cruelly at odds with a patient's wishes and well-being. This leads inexorably to the conclusion that personal medical decisions should be made by those who are most affected by them, in the context of a constitutionally-protected doctor-patient relationship.[17]

[17] Unlike the Missouri Supreme Court, in the vast majority of cases decided since *Roe*, courts have recognized that the constitutional right of privacy places control of personal medical decisions in the hands of patients or their guardians if the patient is incompetent. For example, courts have upheld the patient's right to decide whether to

If the state is given absolute control of a decision as personal and private as the decision whether or not to continue a pregnancy, based on its interest in "potential human life," then it could certainly control these other decisions. If this Court adopts such a statist notion of decisionmaking then the value of "personhood" will have been significantly demeaned for all citizens. Having control over these most important and private decisions is an essential element not only of freedom, but of being a person. As the Massachusetts Supreme Judicial Court put it: "The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life." *Saikewicz*, 370 N.E.2d at 426.

Missouri does not claim that its power is limited to prohibiting abortion. Their sole interest is in protecting *potential* life, rather than *existing* human life. What is most remarkable about virtually all of the briefs submitted to this Court on behalf of Missouri is that they imply that the United States is composed exclusively of state governments and fetuses; women and their physicians are treated as almost irrelevant, and the relationship between a pregnant woman and her physician is ignored.

Missouri seeks to reintroduce the Platonic ideal in a particularly pernicious manner: men are to be treated as "free citizens"; women are to be treated in a manner

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accept or reject medical treatments such as surgery for breast cancer, *In re Yetter*, Northampton Co. Orphans Ct., No. 1973-533 (Williams, Jr.) (Pa. 1973); amputation, *Lane v. Candura*, 376 N.E.2d 1232 (Mass. App. 1978); kidney dialysis, *In the Matter of Spring*, 389 Mass. 629, 405 N.E.2d 115 (1980); respirators, *Satz v. Perlmutter*, 362 So.2d 160 (Fla. App. 1978), *aff'd*. 379 So.2d 359 (Fla. 1980); and artificial nutrition and hydration, *In the Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

similar to the way "slaves" were treated by free physicians in ancient Greece: conversation is to be censored and treatment decisions made without regard for the wishes of the patient. Such a situation is incompatible with both liberty and equal protection. As this Court has properly emphasized: "Our cases long have recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government . . . That promise extends to women as well as to men." *Thornburgh*, 476 U.S. at 772 (1986).

Conclusion

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	NO. C94-119
Plaintiffs,	PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT
vs.	NOTE ON MOTION CALENDAR FEBRUARY 25, 1994
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	ORAL ARGUMENT REQUESTED
Defendants.	

Pursuant to Federal Rule of Civil Procedure 56 and CR 7 of the Rules of the United States District Court for the Western District of Washington, plaintiffs move for summary judgment. The reasons for granting plaintiffs' motion are set forth in Memorandum in Support of Plaintiffs' Motion for Summary Judgment, submitted herewith.

DATED: February 3, 1994.

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By /s/
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Plaintiffs,	)	ANSWER TO COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

COME NOW the defendants in the above entitled cause, the State of Washington and Christine Gregoire, Attorney General of Washington, by and through their attorneys, Christine Gregoire, Attorney General, and William L. Williams, Senior Assistant Attorney General, and answer the complaint of the plaintiffs as follows:

1. In answer to paragraphs 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7 and 2.8 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

2. Defendants admit the allegations contained in paragraph 2.9 of the plaintiffs' complaint.

3. Answering paragraph 2.10 of plaintiffs' complaint, defendants admit that the Attorney General is the chief legal officer of the State of Washington. Defendants affirmatively allege that the Office of the Attorney General was established in Article 3, § 21 of the Constitution of the State of Washington and further that the powers of the Attorney General are set forth in statute, primarily RCW 43.10. Defendants admit that the Attorney General is a proper party defendant to this lawsuit, but deny that she serves in any representative capacity with respect to other law enforcement officers in the state.

4. Paragraphs 1.1, 1.2 and 2.11 of the complaint appear to be assertions of legal theory and not factual allegations and therefore require no answer. To the extent an answer is required, defendants admit that 42 USC § 1983 may be a basis for a suit alleging violation of Fourteenth Amendment rights, but deny that the existence or operation of RCW 9A.36.060 violates, or threatens a violation of, any rights of any plaintiff; defendants admit

the second sentence of paragraph 1.1, and paragraphs 1.2 and 2.11.

5. Defendants deny the allegations contained in paragraphs 3.1, 3.2, and 3.3 of the plaintiffs' complaint.

6. In answer to paragraph 3.4 of the plaintiffs' complaint, defendants are without knowledge sufficient to form a belief as to the truth of the allegations contained therein and therefore, neither admit nor deny those allegations, leaving plaintiffs to their proof.

Defendants allege by way of affirmative defense that plaintiffs have failed to state a claim upon which relief can be granted.

WHEREFORE, having fully answered the complaint of the plaintiffs and having stated an affirmative defense, defendants request that judgment be entered as follows:

1. Dismissing the plaintiffs' complaint;

2. Awarding defendants costs and attorney's fees; and

3. Awarding defendants any additional or further relief which the court finds appropriate or just.

DATED this 11th day of February, 1994.

CHRISTINE GREGOIRE
Attorney General

/s/
William L. Williams
Assistant Attorney General
Attorney for Defendants

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Report I-93-8

Subject: Physician Assisted Suicide
(Resolution 3. A-93--Medical Student Section)

Presented by: John Glasson, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Louis R. Zako, MD, Chair)

Introduction*

Physician-assisted suicide presents one of the greatest contemporary challenges to the medical profession's ethical responsibilities. Proposed as a means toward more humane care of the dying, assisted suicide threatens the very core of the medical profession's ethical integrity.

While the Council on Ethical and Judicial Affairs has long-standing policy opposing euthanasia, it did not expressly address the issue of assisted suicide until its June 1991 report. "Decisions Near the End of Life."[1] In that report, the Council concluded that physician assisted suicide is contrary to the professional role of physicians and that therefore physicians "must not . . . participate in assisted suicide."[1] Previously, the Council had issued reports rejecting the use of euthanasia. In June 1977, the Council stated that "mercy killing or euthanasia--is contrary to

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* In accordance with the Joint Report of the Council on Ethical and Judicial Affairs and the Council on Constitution and Bylaws (I-91), this report may be adopted, not adopted, or referred. It may only be amended, with the concurrence of the Council, to clarify its meaning.

public policy, medical tradition, and the most fundamental measures of human value and worth."[2] Similarly in June 1988, the Council reaffirmed "its strong opposition to 'mercy killing.'"[3]

Broad public debate of assisted suicide was sparked in June 1990, when Dr. Jack Kevorkian assisted in the suicide of Janet Adkins (NY Times, June 6, 1990:A1). The debate was advanced in March 1991 when Dr. Timothy Quill disclosed his assistance in the suicide of Diane Trumbull.[4] Other public events quickly followed. Physician assisted suicide, together with euthanasia, was placed on the public ballot in Washington State, in November 1991, and in California in November 1992. Both times, voters turned down proposals to legalize physician assisted dying (USA Today, August 9, 1993:13A). In September 1993, by a vote of 5-4, Canada's Supreme Court denied a woman's request to end her life by assisted suicide (NY Times, October 1, 1993:A8). In 1994, voters in Oregon will decide whether to legalize assisted suicide in their state.

Resolution 3, introduced at the 1993 Annual Meeting by the Medical Student Section and referred to the Board of Trustees by the House of Delegates, requested an ethical study of assisted suicide. In this report, the Council revisits the issue of physician assisted suicide.

Definitions

Assisted suicide occurs when a physician provides a patient with the medical means and/or the medical knowledge to commit suicide. For example, the physician could provide sleeping pills and information about the lethal dose, while aware that the patient is contemplating suicide. In physician assisted suicide, the patient performs the life-ending act, whereas in euthanasia, the physician administers the death-causing drug or other agent.[5]

Assisted suicide and euthanasia should not be confused with the provision of a palliative treatment that may hasten the patient's death ("double effect"). The intent of the palliative treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a possible side effect of the treatment. It is ethically acceptable for a physician to gradually increase the appropriate medication for a patient, realizing that the medication may depress respiration and cause death.[1]

Assisted suicide also must be distinguished from withholding or withdrawing life-sustaining treatment, in which the patient's death occurs because the patient or the patient's proxy, in consultation with the treating physician, decides that the disadvantages of treatment outweigh its advantages and therefore that treatment is refused.[1]

Ethical Considerations

1. Inappropriate extension of the right to refuse treatment. In granting patients the right to refuse life-sustaining medical treatment, society has acknowledged the right of patients to self-determination on matters of their medical care even if the exercise of that self-determination results in the patient's death. Because any medical treatment offers both benefits and detriments, and people attach different values to those benefits and detriments, only the patient can determine whether the advantages of treatment outweigh the disadvantages. As the Council has previously concluded, "[t]he principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity."[1]

Although a patient's choice of suicide also represents an expression of self-determination, there is a fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment. The right of self-

determination is a right to accept or refuse offered interventions, but not to decide what should be offered. The right to refuse life-sustaining treatment does not automatically entail a right to insist that others take action to bring on death.[6(p.121)]

When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

For a number of reasons, the medical profession has rejected assisted suicide as fundamentally inconsistent with the professional role of physicians as healers. Indeed, according to the Hippocratic Oath, physicians shall "give no deadly drug to any, though it be asked of [them], nor will [they] counsel such." Physicians serve patients not because patients exercise self-determination but because patients are in need. Therefore, a patient may not insist on treatments that are inconsistent with sound medical practices. Rather, physicians provide treatments that are designed to make patients well, or as well as possible.[7] The physician's role is to affirm life, not to hasten its demise.

Permitting assisted suicide would compromise the physician's professional role also because it would involve physicians in making inappropriate value judgments about the quality of life. Indeed, with the refusal of life-sustaining treatment, society does not limit the right to

refuse treatment only to patients who meet a specific standard of suffering. With refusal of treatment, the state recognizes that the patient (or the patient's proxy) alone can decide that there no longer is a meaningful quality of life.

Objections to causing death also underlie religious views on assisted suicide. Most of the world's major religions oppose suicide in all forms and do not condone physician-assisted suicide even in cases of suffering or imminent death. In justification of their position, religions generally espouse common beliefs about the sanctity of human life, the appropriate interpretation of suffering, and the subordination of individual autonomy to a belief in God's will or sovereignty.[8]

2. <u>The physician's role</u>. The relief of suffering is an essential part of the physician's role as healer, and some patients seek assisted suicide because they are suffering greatly. Suffering is a complex process that may exist in one or several forms, including pain, loss of self-control and independence, a sense of futility, loss of dignity and fear of dying. It is incumbent upon physicians to discuss and identify the elements contributing to the patient's suffering and address each appropriately. The patient, and family members as well, should participate with the physician to ensure that measures to provide comfort will be given the patient in a timely fashion.

One of the greatest concerns reported by patients facing a terminal illness or chronic debilitation is the fear that they will be unable to receive adequate relief for their pain.[9] Though there is some basis for this fear in a small number of cases, for most patients pain can be adequately controlled.[10,11] Inadequate pain relief is only rarely due to the unavailability of effective pain control medications; more often, it may be caused by reluctance on the part of

physicians to use these medications aggressively enough to sufficiently alleviate the patient's pain. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area.

Pain control medications should be employed in whatever dose necessary, and by whatever route necessary to fully relieve the patient's pain.[9] The patient's treatment plan should be tailored to meet the particular patient's needs. Some patients will request less pain control in order to remain mentally lucid; others may need to be sedated to the point of unconsciousness. Ongoing discussions with the patient, if possible, or with the patient's family or surrogate decision maker will be helpful in identifying the level of pain control necessary to relieve the patient's suffering in accordance with the patient's treatment goals. Techniques of patient controlled analgesia (PCA) enhance the sense of control of terminally ill patients, and, for this reason, are particularly effective. Often, it is the loss of control, rather than physical pain, that causes the most suffering for dying patients.

The first priority for the care of patients facing severe pain as a result of a terminal illness or chronic condition should be the relief of their pain. Fear of addiction to pain medications should not be a barrier to the adequate relief of pain. Nor should physicians be concerned about legal repercussions or sanctions by licensing boards. The courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. Indeed, it is well accepted both ethically and legally that pain medications may be administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of causing addiction or of causing death through respiratory depression.[1]

Relieving the patient's psychosocial and other suffering is as important as relieving the patient's pain. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. Patients in these circumstances must be managed "in a setting of [the patient's] own choosing, as free as possible from pain and other burdensome symptoms, and with the optimal psychological and spiritual support of family and friends."[12] Because the loss of control may be the greatest fear of dying patients, all efforts should be made to maximize the patient's sense of control.

Accomplishing these goals requires renewed efforts from physicians, nurses, family members and other sources of psychological and spiritual support. Often, the patient's despair with his or her quality of life can be relieved by psychiatric intervention.[13] Seriously ill patients contemplating suicide may develop a renewed desire to live as a result of counseling and/or anti-depressant medications. When requests for assisted suicide occur, it is important to provide the patient with an evaluation by a health professional with expertise in psychiatric aspects of terminal illness.

The hospice movement has made great strides in providing comfort care to patients at the end of life. In hospice care, the patient's symptoms, including pain, are aggressively treated to make the patient as comfortable as possible, but efforts to extend the patient's life are usually not pursued.[14,15,16] Hospice patients are often cared for at home, or, if their condition requires care to be delivered in an institutional setting, intrusive medical technology is kept to a minimum. The provision of a humane, low technology environment in which to spend their final days can

go far in alleviating patients' fears of an undignified, lonely, technologically dependent death.

Physicians must not abandon or neglect the needs of their terminally ill patients. Indeed, the desire for suicide is a signal to the physician that more intensive efforts to comfort and care for the patient are needed. Physicians, family and friends can help patients near the end of life by their presence and by their loving support. Patients may feel obligated to die in order to spare their families the emotional and financial burden of their care or to spare limited societal resources for other health care needs. While patients may rationally and reasonably be concerned about the burden on others, physicians and family members must reassure patients that they are under no obligation to end their lives prematurely because of such concerns.

In some cases, terminally ill patients voluntarily refuse food or oral fluids. In such cases, patient autonomy must be respected and forced feeding or aggressive parenteral rehydration should not be employed. Emphasis should be placed on renewed efforts at pain control, sedation and other comfort care for the associated discomfort.

3. "Slippery slope" concerns. Permitting assisted suicide opens the door to policies that carry far greater risks. For example, if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths. Given the acceptance of withdrawal of life-sustaining treatment by proxies for incompetent patients, it would be easy for society to permit euthanasia for incompetent patients by proxy.

The Dutch experience with euthanasia demonstrates the risks of sanctioning physician assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia that are similar to the criteria proposed for assisted suicide in the United States. In the leading study of euthanasia in the Netherlands,[17] however, researchers found that, in about 28% of cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In a number of cases, the decision to end the patient's life was made by a surrogate decision-maker since the patient had lost decision-making capacity by the time the decision to employ euthanasia was made.

Recommendations

1. Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
2. It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
3. Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.

4. Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
5. Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations.

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Council Report

Decisions Near the End of Life [*][**]

Council on Ethical and Judicial Affairs
American Medical Association

OVER the last 50 years, people have become increasingly concerned that the dying process is too often needlessly protracted by medical technology and is consequently marked by incapacitation, intolerable pain, and indignity. In one public opinion poll, 68% of respondents believed that "people dying of an incurable painful disease should be allowed to end their lives before the disease runs its course."[1] A number of comparable surveys indicate similar public sentiment.[2]

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* From the Council on Ethical and Judicial Affairs American Medical Association, Chicago, Ill.

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Since the turn of the century, there has been a dramatic shift in the places where people die. Sixty years ago, the vast majority of deaths occurred at home. Now most people die in hospitals or long-term care facilities. Approximately 75% of all deaths in 1987 occurred in hospitals and long-term care institutions,[3] up from 50% in 1949, 61% in 1958, and 70% in 1977.[4] This transition from the privacy of the home to medical institutions has increased public awareness and concern about medical decisions near the end of life. "Since deaths which occur in institutions are more subject to scrutiny and official review, decisions for death made there are more likely to enter public consciousness."[5]

The development of sophisticated life support technologies now enables medicine to intervene and forestall death for most patients. Do-not-resuscitate orders are now commonplace.[6] The Office of Technology Assessment Task Force estimated in 1988 that 3775 to 6575 persons were dependent on mechanical ventilation and 1404 500 persons were receiving artificial nutritional support.[7] This growing capability to forestall death has contributed to the increased attention to medical decisions near the end of life.[5]

The Council has issued opinions on withdrawing and withholding life-prolonging treatment from patients who are terminally ill or permanently unconscious and has also published reports concerning do-not-resuscitate orders,[9,10] euthanasia,[11] and withdrawal of life--prolonging treatment from permanently unconscious patients.[12] This report will re-examine the Council's existing positions and will expand the analysis to include physician-assisted suicide and withdrawing or withholding life-sustaining treatment for patients who are neither terminally ill nor permanently unconscious. The report will focus on competent patients in nonemergency situations. The issue of decisions near

the end of life for incompetent patients is addressed in a separate report by the Council.[13]

DEFINITIONS

The decisions near the end of life examined in this report are those decisions regarding actions or intentional omissions by physicians that will foreseeably result in the deaths of patients. In particular, these decisions concern the withholding or withdrawing of life-sustaining treatment, the provision of a palliative treatment that may have fatal side effects, euthanasia, and assisted suicide.

Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. At one time, the term *passive euthanasia* was commonly used to describe withholding or withdrawing life-sustaining treatment. However, many experts now refrain from using the term passive euthanasia.

The provision of a palliative treatment that may have fatal side effects is also described as *double-effect euthanasia*. The intent of the treatment is to relieve pain and suffering, not to end the patient's life, but the patient's death is a foreseeable potential effect of the treatment. An example is gradually increasing the morphine dosage for a patient to relieve severe cancer pain, realizing that large enough doses of morphine may depress respiration and cause death.

Euthanasia is commonly defined as the act of bringing about the death of a hopelessly ill and suffering person in a relatively quick and painless way for reasons of mercy. In this report, the term euthanasia will signify the medical administration of a lethal agent to a patient for the purpose

of relieving the patient's intolerable and incurable suffering.

Voluntary euthanasia is euthanasia that is provided to a competent person on his or her informed request. *Nonvoluntary euthanasia* is the provision of euthanasia to an incompetent person according to a surrogate's decision. *Involuntary euthanasia* is euthanasia performed without a competent person's consent. This report will not examine involuntary euthanasia further, since it clearly would never be ethically acceptable.

Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing the immediate life-ending action (eg, administering a lethal injection). *Assisted suicide* occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

Discussions about life-ending acts by physicians often refer to the patient's "competence" or "decision-making capacity." The two terms are often used interchangeably. However, *competence* can also refer to a legal standard regarding a person's soundness of mind. *Decision-making capacity* signifies the ability to make a particular decision and is not considered a legal standard. "Competence" for the Council's purposes will mean "decision-making capacity."

The evaluation of a person's decision-making capacity is an assessment of the person's capabilities for understanding, communicating, and reasoning. Patients should not be judged as lacking decision-making capacity based on the view that what they decide is unreasonable." People are entitled to make decisions that others think are foolish

as long as their choices are arrived at through a competently reasoned process and are consistent with their personal values.

ETHICAL FRAMEWORK

Determining the ethical responsibilities of physicians when patients wish to die requires a close examination of the physician's role in society. Physicians are healers of disease and injury, preservers of life, and relievers of suffering. Ethical judgments become complicated, however, when these duties conflict. The four instances in which physicians might act to hasten death or refrain from prolonging life involve conflicts between the duty to relieve suffering and the duty to preserve life.

The considerations that must be weighed in each case are: (1) the principle of patient autonomy and the corresponding obligation of physicians to respect patients' choices; (2) whether what is offered by the physician is sound medical treatment; and (3) the potential consequences of a policy that permits physicians to act in a way that will foreseeably result in patients' deaths.

Patient Autonomy

The principle of patient autonomy requires that competent patients have the opportunity to choose among medically indicated treatments and to refuse any unwanted treatment. Absent countervailing obligations, physicians must respect patients' decisions. Treatment decisions often involve personal value judgments and preferences in addition to objective medical considerations. We demonstrate respect for human dignity when we acknowledge "the freedom [of individuals] to make choices in accordance with their own values."[15]

Sound Medical Treatment

The physician's obligation to respect a patient's decision does not require a physician to provide a treatment that is not medically sound. Indeed, physicians are ethically prohibited from offering or providing unsound treatments. Sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.

This criterion of soundness arises from the medical ethical principles of beneficence and nonmaleficence. The principle of *nonmaleficence* prohibits physicians from using their medical knowledge or skills to do harm, on balance, to their patients, while the principle of *beneficence* requires that medical knowledge and skills be used to benefit patients.

Generally, a treatment that is likely to cause the death of a patient violates the principle of nonmaleficence, and a failure to save a patient's life is contrary to beneficence. However, for these decisions near the end of life the patient does not consider his or her death to be an absolutely undesirable outcome.

Practical Considerations

Policies governing decisions near the end of life must also be evaluated in terms of their practical consequences. The ethical acceptability of a policy depends on the benefits and costs that result from the policy. In addition to the impact on individual cases (eg, patients will die according to their decision to have life supports withdrawn), there are likely to be serious societal consequences of policies regarding physicians' responsibilities to dying patients.

WITHHOLDING AND WITHDRAWING LIFE-SUSTAINING TREATMENT

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is the patient's death.[4] The right of competent patients to forgo life-sustaining treatment has been upheld in the courts (for example, *In re Brooks Estate,* 32 Ill2d 361, 205 NE2d 435 [1965]; *In re Osborne,* 294 A2d 372 [1972]) and is generally accepted by medical ethicists.[4]

Decisions that so profoundly affect a patient's well-being cannot be made independent of a patient's subjective preferences and values.[16] Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death.[7] When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would likely be painful, nauseating, and debilitating. Similarly, when a patient is dying, there may be a choice between returning home to a natural death, or remaining in the hospital, attached to machinery, where the patient's life might be prolonged a few more days or weeks. In both cases, individuals might weigh differently the value of additional life vs the burden of additional treatment.

The withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence. The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When a physician withholds or withdraws a treatment on the request of a

patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withholding is not a treatment, but the forgoing of a treatment.

Some commentators argue that if a physician has a strong moral objection to withdrawing or withholding life-sustaining treatment, the physician may transfer the patient to another physician who is willing to comply with the patient's wishes.[4] It is true that a physician does not have to provide a treatment, such as an abortion, that is contrary to his or her moral values. However, if a physician objects to withholding or withdrawing the treatment and forces unwanted treatment on a patient, the patient's autonomy will be inappropriately violated even if it will take only a short time for the patient to be transferred to another physician.

Withdrawing or withholding some life-sustaining treatments may seem less acceptable than others. The distinction between "ordinary" vs "extraordinary" treatments has been used to differentiate ethically obligatory vs ethically optional treatments.[17] In other words, ordinary treatments must be provided, while extraordinary treatment may be withheld or withdrawn. Varying criteria have been proposed to distinguish ordinary from extraordinary treatment. Such criteria include customariness, naturalness, complexity, expense, invasiveness, and balance of likely benefits vs burdens of the particular treatment.[17,18] The ethical significance of all these criteria essentially are subsumed by the last criterion--the balance of likely benefits vs the burdens of the treatment.[17]

When a patient is competent, this balancing must ultimately be made by the patient. As stated earlier, the evaluation of whether life-sustaining treatment should be initiated, maintained, or forgone depends on the values and preferences of the patient. Therefore, treatments are not objectively ordinary or extraordinary. For example, artificial nutrition and hydration have frequently been cited as an objectively ordinary treatment which, therefore, must never be forgone. However, artificial nutrition and hydration can be very burdensome to patients. Artificial nutrition and hydration immobilize the patient to a large degree, can be extremely uncomfortable (restraints are sometimes used to prevent patients from removing nasogastric tubes), and can entail serious risks (for example, surgical risks from insertion of a gastrostomy tube and the risk of aspiration pneumonia with a nasogastric tube).

Aside from the ordinary vs extraordinary argument, the right to refuse artificial nutrition and hydration has also been contested by some because the provision of food and water has a symbolic significance as an expression of care and compassion.[19] These commentators argue that withdrawing or withholding food and water is a form of abandonment and will cause the patient to die of starvation and/or thirst. However, it is far from evident that providing nutrients through a nasogastric tube to a patient for whom it is unwanted is comparable to the typical human ways of feeding those who are hungry.[18] In addition, discomforting symptoms can be palliated so that a death that occurs after forgoing artificial nutrition and/or hydration is not marked by substantial suffering.[20,21] Such care requires constant attention to the patient's needs. Therefore, when comfort care is maintained, respecting a patient's decision to forgo artificial nutrition and hydration will not constitute an abandonment of the patient, symbolic or otherwise.

There is also no ethical distinction between withdrawing and withholding life-sustaining treatment.[4,15,17] Withdrawing life support may be emotionally more difficult than withholding life support because the physician performs an action that hastens death. When life-sustaining treatment is withheld, on the other hand, death occurs because of an omission rather than an action. However, as most bioethicists now recognize, such a distinction lacks ethical significance.[4,15,17] First, the distinction is often meaningless. For example, if a physician fails to provide a tube feeding at the scheduled time, would it be a withholding or a withdrawing of treatment? Second, ethical relevance does not lie with the distinction between acts and omissions, but with other factors such as the motivation and professional obligations of the physician. For example, refusing to initiate ventilator support despite the patient's need and request because the physician has been promised a share of the patient's inheritance is clearly ethically more objectionable than stopping a ventilator for a patient who has competently decided to forgo it. Third, prohibiting the withdrawal of life support would inappropriately affect a patient's decision to initiate such treatment. If treatment cannot be stopped once it is initiated, patients and physicians may be more reluctant to begin treatment when there is a possibility that the patient may later want the treatment withdrawn.[4]

While the principle of autonomy requires that physicians respect competent patients' requests to forgo life-sustaining treatments, there are potential negative consequences of such a policy. First, deaths may occur as a result of uninformed decisions or from pain and suffering that could be relieved with measures that will not cause the patient's death. Further, subtle or overt pressures from family, physicians, or society to forgo life-sustaining treatment may render the patient's choice less than free.

These pressures could revolve around beliefs that such patients' lives no longer possess social worth and are an unjustifiable drain of limited health resources.

The physician must ensure that the patient has the capacity to make medical decisions before carrying out the patient's decision to forgo (or receive) life-sustaining treatment. In particular, physicians must be aware that the patient's decision-making capacity can be diminished by a misunderstanding of the medical prognosis and options or by a treatable state of depression. It is also essential that all efforts be made to maximize the comfort and dignity of patients who are dependent on life-sustaining treatment and that patients be assured of these efforts. With such assurances, patients will be less likely to forgo life support because of suffering or anticipated suffering that could be palliated.

The potential pressures on patients to forgo life-sustaining treatments are an important concern. The Council believes that the medical profession must be vigilant against such tendencies, but that the greater policy risk is of undermining patient autonomy.

PROVIDING PALLIATIVE TREATMENTS THAT MAY HAVE FATAL SIDE EFFECTS

Health care professionals have an ethical duty to provide optimal palliative care to dying patients. At present, many physicians are not informed about the appropriate doses, frequency of doses, and alternate modalities of pain control for patients with severe chronic pain. In particular, inappropriate concerns about addiction too often inhibit physicians from providing adequate analgesia to dying patients. Physicians should inform the patient and the family that concentrated efforts to relieve pain will be a priority in the care of the patient, since fear

of pain is "one of the most pervasive causes of anxiety among patients, families and the public."[2]

The level of analgesia necessary to relieve the patient's pain, however, may also have the effect of shortening the patient's life. The Council stated in its 1988 report on euthanasia that "the administration of a drug necessary to ease the pain of a patient who is terminally ill and suffering excruciating pain may be appropriate medical treatment even though the effect of the drug may shorten life."[11] The Council maintains this position and further emphasizes that a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.

The ethical distinction between providing palliative care that may have fatal side effects and providing euthanasia is subtle because in both cases the action that causes death is performed with the purpose of relieving suffering. The intent of the former is to relieve suffering despite the fatal side effects, while the intent of the latter is to cause death as a means by which relief of suffering is achieved. Most medical treatments entail some undesirable side effects. In general, the patient has a right to decide either to risk the side effects or to forgo the treatment. It does not follow from this reasoning that a patient also has a right to choose euthanasia as a medical treatment for their suffering.

An important concern is that patients who are not fully informed about their prognosis and options may make decisions that unnecessarily shorten their lives. In addition, severe pain might diminish the patient's capacity to decide whether to choose a treatment that risks death. Caution when determining decision-making capacity in this

situation, therefore, must be exercised, and patients should be fully informed.

EUTHANASIA

Euthanasia is the medical administration of a lethal agent in order to relieve a patient's intolerable and untreatable suffering. Whether or not a physician may use the skills or knowledge of medicine to cause an "easy" death for a patient who requests such assistance has been debated as early as the time of Hippocrates. Recently, euthanasia has been gaining support from the public and some in the medical profession. In the Netherlands, while physician-performed euthanasia remains illegal, physicians have not been prosecuted since 1984 when they follow certain criteria.[23] These criteria include that (1) euthanasia is explicitly and repeatedly requested by the patient and there is no doubt that the patient wants to die; (2) the mental and physical suffering is severe with no prospect for relief; (3) the patient's decision is well-informed, free, and enduring; (4) all options for alternate care have been exhausted or refused by the patient; and (5) the physician consults another physician.[24] The frequency of euthanasia in the Netherlands has been estimated to range from 2000 to 20000 persons per year.[23] Recently, the first nationwide study of the practice of euthanasia in the Netherlands estimated the incidence of euthanasia to be 1900 persons per year.[25]

In the United States there has been growing public support for legalized euthanasia. The Hemlock Society, an organization dedicated to legalizing voluntary euthanasia and assisted suicide, has doubled its membership in the past 5 years to approximately 33000.[26] Recently, an initiative in Washington State that would have legalized euthanasia for terminally ill patients was put to a vote. Although the

initiative was unsuccessful, 44% of the voters supported the initiative.[27]

Though the principle of patient autonomy requires that competent patients be given the opportunity to choose among offered medical treatments and to forgo any treatment, it does not give patients the right to have a physician perform a treatment to which the physician has objections. Though patients have a right to refuse life-sustaining treatment, they do not have a right to receive euthanasia. There is an autonomy interest in directing one's death, but this interest is more limited in the case of euthanasia than in the case of refusing life support.

The question remains whether it is ethical for a physician to agree to perform euthanasia. To approach this question one must look to the principles of beneficence and nonmaleficence and to the larger policy implications of condoning physician-performed euthanasia.

Can euthanasia ever constitute sound medical treatment? Any treatment designed to cause death is generally considered detrimental to the patient's well-being, and therefore unsound. However, proponents of euthanasia argue that euthanasia is a sound treatment of last resort for the relief of intolerable pain and suffering. From the perspective of competent patients who request euthanasia in the face of such suffering, death may be preferable, on balance, to continued life.

On the other hand, most pain and suffering can be alleviated. The technology of pain management has advanced to the point where most pain is now controllable. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.[22]

There may be cases, however, where a patient's pain and suffering is not reduced to a tolerable level and the patient requests a physician to help him or her die.[2,22] If a patient's pain and suffering are unrelievable and intolerable, using medical expertise to aid an easy death on the request of the patient might seem to be the humane and beneficent treatment for the patient.

However, there are serious risks associated with a policy allowing physician-performed euthanasia. There is a long-standing prohibition against physicians killing their patients, based on a commitment that medicine is a profession dedicated to healing, and that its tools should not be used to cause patients' deaths. Weakening this prohibition against euthanasia, even in the most compelling situations, has troubling implications.[28,29] Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Two noted ethicists have expressed the role of this prohibition:

> The prohibition of killing is an attempt to promote a solid basis for trust in the role of caring for patients and protecting them from harm. This prohibition is both instrumentally and symbolically important, and its removal would weaken a set of practices and restraints that we cannot easily replace.[17]

If euthanasia by physicians were to be condoned, the fact that physicians could offer death as a medical treatment might undermine public trust in medicine's dedication to preserving the life and health of patients.[26] Some patients may fear the prospect of involuntary or nonvoluntary euthanasia if their lives are no longer deemed valuable as judged by physicians, their family, or society.[30] Other patients who trust their physicians' judgments may not feel

free to resist the suggestion that euthanasia may be appropriate for them.[30-32]

Another risk is that physicians and other health care providers may be more reluctant to invest their energy and time serving patients whom they believe would benefit more from a quick and easy death. Caring for dying patients is taxing on physicians who must face issues of their own mortality in the process, and who often perceive such care as a reminder of their failure to cure these patients.[4,15] In addition, the increasing pressure to reduce health care costs may serve as another motivation to favor euthanasia over longer-term comfort care.

Allowing physicians to perform euthanasia for a limited group of patients who may truly benefit from it will present difficult line-drawing problems for medicine and society. In specific cases it may be hard to distinguish which cases fit the criteria established for euthanasia. For example, if the existence of unbearable pain and suffering was a criterion for euthanasia, the definition of unbearable pain and suffering could be subject to different interpretations.

Furthermore, determining whether a patient will benefit from euthanasia requires an intimate understanding of the patient's concerns, values, and pressures that may be prompting the euthanasia request. In the Netherlands, physicians who provide euthanasia generally have a lifelong relationship with the patient and the patient's family, which enables the physician to have access to this vital information.[33] In the United States, however, physicians rarely have the depth of knowledge about their patients that would be necessary for an appropriate evaluation of the patient's request for euthanasia.

More broadly, the line-drawing necessary for the establishment of criteria for euthanasia is also problematic.

If competent patients can receive euthanasia, can family members request euthanasia for an incompetent patient? Would it be acceptable for physicians to perform euthanasia on any competent individuals who request it? Furthermore, since it will be physicians and the state who ultimately answer these questions, value judgments about patients' lives will be made by a person or entity other than the patients.

Since it is unclear at this time where these lines should be drawn, the proposition of allowing euthanasia is particularly troublesome. A potential exists for a gradual distortion of the role of medicine into something that starkly contrasts with the current vision of a profession dedicated to healing and comforting.

Furthermore, in the United States there is currently little data regarding the number of euthanasia requests, the concerns behind the requests, the types and degree of intolerable and unrelievable suffering, or the number of requests that have been granted by health care providers. Before euthanasia can ever be considered a legitimate medical treatment in this country, the needs behind the demand for physician-provided euthanasia must be examined more thoroughly and addressed more effectively. A thorough examination would require a more open discussion of euthanasia and the needs of patients who are making requests. The existence of patients who find their situations so unbearable that they request help from their physicians to die must be acknowledged, and the concerns of these patients must be a primary focus of medicine. Rather than condoning physician-provided euthanasia, medicine must first respond by striving to identify and address the concerns and needs of dying patients.

PHYSICIAN-ASSISTED SUICIDE

Physician-assisted suicide has only recently become the focus of public attention. In June 1990, Dr Jack Kevorkian assisted the death of a person with the use of a "suicide machine," which he invented. This case has been criticized by many for the irresponsible way in which it was carried out by the physician.[26] Kevorkian has since used his suicide machine to assist the suicides of two more persons. Last March, an article was published in the *New England Journal of Medicine* by a physician who described his role in assisting his patient's suicide.[34] The care and compassion evidenced by the physician and the reasoned decision-making process of the patient marked this account as truly compelling. Besides these very public cases of physician-assisted suicide, there is reason to believe that it has been occurring for some time.[2]

There is an ethically relevant distinction between euthanasia and assisted suicide that makes assisted suicide an ethically more attractive option. Physician-assisted suicide affords a patient a more autonomous way of ending his or her life than does euthanasia. Since patients must perform the life-ending act themselves, they would have the added protection of being able to change their minds and stop their suicides up until the last moment.

However, the ethical objections to physician-assisted suicide are similar to those of euthanasia since both are essentially interventions intended to cause death. Physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also has many of the same societal risks as euthanasia, including the potential for coercive financial and societal pressures on patients to choose suicide. Further, determining the criteria for assisting a patient's suicide and determining

whether a particular patient meets the criteria are as problematic as deciding who may receive euthanasia.

While in highly sympathetic cases physician-assisted suicide may seem to constitute beneficent care, due to the potential for grave harm the medical profession cannot condone physician-assisted suicide at this time. The medical profession instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care.

CONCLUSIONS

* The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

* There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

* Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

* Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control

may decrease dramatically the demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great in this culture to condone euthanasia or physician-assisted suicide at this time.

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MODEL PENAL CODE

§ 210.5 Causing or Aiding Suicide

. . .

(2) **Aiding or Soliciting Suicide as an Independent Offense.** A person who purposely aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor.

STATE STATUTES

ALASKA

Sec. 1141.120. Manslaughter. (a) A person commits the crime of manslaughter if the person

. . .

(2) intentionally aids another person to commit suicide.

ARIZONA

§ 13-1103. Manslaughter; classification

A. A person commits manslaughter by:

. . .

3. Intentionally aiding another to commit suicide; or

ARKANSAS

5-10-104. Manslaughter.

. . .

(2) He purposely causes or aids another person to commit suicide;

CALIFORNIA

§ 401. Suicide; aiding, advising, or encouraging

Every person who deliberately aids, or advises, or encourages another to commit suicide, is guilty of a felony.

COLORADO

18-3-104. Manslaughter. (1) A person commits the crime of manslaughter if:

. . .

(b) Such person intentionally causes or aids another person to commit suicide; or

CONNECTICUT

§ 53A-56. Manslaughter in the second degree: Class C felony

(a) A person is guilty of manslaughter in the second degree when: . . . (2) he intentionally causes or aids another person, other than by force, duress or deception, to commit suicide.

Commission Comment--1971

Manslaughter in the second degree. This section covers two types of homicide: recklessly causing the death of another; and intentionally causing or aiding another person to commit suicide.

. . .

The second part, causing or aiding a suicide, is aimed at such situations as aiding, out of the feelings of sympathy, the suicide of one inflicted with a painful and incurable disease. While such conduct is blameworthy, the possible mitigating circumstances justify its treatment as manslaughter, rather than murder.

DELAWARE

§ 645. Promoting suicide; class F felony [Amendment effective with respect to crimes committed June 30, 1990, or thereafter].

A person is guilty of promoting suicide when he intentionally causes or aids another person to attempt suicide, or when he intentionally aids another person to commit suicide.

FLORIDA

782.08. Assisting self-murder

Every person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

ILLINOIS

12-31. Inducement to commit suicide

§ 12-31. Inducement to Commit Suicide. (a) A person commits the offense of inducement to commit suicide when he coerces another to commit suicide and the other person commits suicide as a direct result of the coercion, and he exercises substantial control over the other person through (1) control of the other person's physical location or circumstances; (2) use of psychological pressure; or (3) use of actual or ostensible religious, political, social, philosophical or other principles.

INDIANA

35-42-1-2.5 Assisting suicide.--(a) This section does not apply to the following:

(1) A licensed health care provider who administers, prescribes, or dispenses medications or procedures to

relieve a person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, unless such medications or procedures are intended to cause death.

(2) The withholding or withdrawing of medical treatment or life-prolonging procedures by a licensed health care provider, including pursuant to IC 16-8-11 (living wills and life-prolonging procedures), IC 16-8-12 (health care consent), or IC 30-5 (power of attorney).

(b) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following commits assisting suicide, a Class C felony:

(1) Provides the physical means by which the other person attempts or commits suicide.

(2) Participates in a physical act by which the other person attempts or commits suicide.

KANSAS

21-3406. Assisting suicide. Assisting suicide is intentionally advising, encouraging or assisting another in the taking of the other's life which results in a suicide or attempted suicide.

Assisting suicide is a severity level 9, person felony.

MAINE

§ 204. Aiding or soliciting suicide

1. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide.

2. Aiding or soliciting suicide is a Class D crime.

Comment to former section 206--1975

There is no counterpart to this section in the present law. It is included in the code in order to deter conduct aimed at causing another to take his life. The participation of the victim in bringing about his own death does not make the forbidden conduct free from fault. The requirement that there be a successful or unsuccessful suicide attempt adds a safeguard designed to corroborate the defendant's intention. [Footnote omitted.]

MICHIGAN

AN ACT to ◆ [prohibit certain acts pertaining to the assistance of suicide]; to provide for the development of legislative recommendations concerning certain issues related to death and dying [, including assistance of suicide]; ◆ [to create the Michigan commission on death and dying]; [to prescribe its membership, powers, and duties;] to prescribe penalties; and to repeal certain parts of this act on a specific date.

§28.547(121) Commission on death and dying; creation.] Sec. 1. (1) The legislature finds that the voluntary self-termination of human life, with or without assistance, raises serious ethical and public health questions in the state. To study this problem and to develop recommendations for legislation, the Michigan commission on death and dying is created.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1021.)

§28.547(122) Definitions.] Sec. 2. (1) As used in this act:

(a) "Commission" means the Michigan commission on death and dying created in section 3.

(b) "Legislative council" means the legislative council established under section 15 of article IV of the state constitution of 1963.

(c) "Licensed health care professional" means any of the following:

(i) A physician or physician's assistant licensed or authorized to practice under part 170 or 175 of the public health code [, being sections 333.17001 to 333.17088 and 333.17501 to 333.17556 of the Michigan Compiled Laws].

(ii) A registered nurse or licensed practical nurse licensed or authorized to practice under part 172 of the public health code [, being sections 333.17201 to 333.17242 of the Michigan Compiled Laws].

(iii) A pharmacist licensed under part 177 of the public health code[, being sections 333.17701 to 333.17770 of the Michigan Compiled Laws].

(d) "Patient" means a person who engages in an act of voluntary self-termination.

(e) "Public health code" means Act No. 368 of the Public Acts of 1978, being sections 333.1101 to 333.25211 of the Michigan Compiled Laws.

(f) "The voluntary self-termination of life", "voluntary self-termination", and "self-termination" mean conduct by which a person expresses the specific intent to end, and attempts to cause the end of, his or her life, but do not include the administration of medication or medical treatment intended by a person to relieve his or her pain or discomfort, unless that administration is also independently and specifically intended by the person to cause the end of his or her life.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1022.)

§28.547(123) Nomination and appointment of members.] Sec. 3.(1) The Michigan commission on death and dying is created within the 'egislative council. In

accordance with its own rules and procedures, each of the following may nominate 2 persons for appointment to the commission:

(a) American association of retired persons.
(b) American civil liberties union of Michigan.
(c) Citizens for better care.
(d) Health care association of Michigan.
(e) Hemlock of Michigan.
(f) Michigan association for retarded citizens.
(g) Michigan association of osteopathic physicians and surgeons.
(h) Michigan association of suicidology.
(i) Michigan council on independent living.
(j) Michigan head injury survivor's council.
(k) Michigan hospice organization.
(l) Michigan hospital association.
(m) Michigan nonprofit homes association.
(n) Michigan nurses association.
(o) Michigan psychiatric society.
(p) Michigan psychological association.
(q) Michigan senior advocates council.
(r) Michigan state medical society.
(s) National association of social workers, Michigan division.
(t) Right to life of Michigan, inc.
(u) State bar of Michigan.
(v) Prosecuting attorneys association of Michigan.

Legislative council; selection of commission member and alternate.] (2) Within 30 days after receiving notice of the nominations of an organization listed in subsection (1), the chairperson and alternate chairperson of the legislative council shall select from the nominees of that organization a member and a person to serve as that member's alternate on the commission.

Majority of members to constitute quorum.] (3) A majority of commission members appointed constitute a quorum.

Initial meeting; election of officers; establishment of rules of proceeding; rights of alternate members.] (4) The commission shall convene its first meeting within 90 days after the effective date of this act, at which the members shall elect from members of the commission a chairperson, vice-chairperson, and secretary. The commission shall establish rules governing commission proceedings. These rules shall provide alternate members with full rights of participation, other than voting, in all commission proceedings.

Subsequent meetings; calling of meetings by chairperson or commission majority; notice.] (5) Following its first meeting, the commission shall meet as often as necessary to fulfill its duties under this act. Either the chairperson or a majority of the appointed members may call a meeting upon 7 days' written notice to the commission members.

Deliberations; involvement of members of the public and certain groups.] (6) In its deliberations, the commission shall provide for substantial involvement from the academic, health care, legal, and religious communities, as well as from members of the general public.

Death or absence of member; duties of alternate.] (7) Upon the death or resignation of a commission member, the person serving as his or her alternate shall succeed that member. If a member of the commission is absent from a commission meeting, the person serving as his or her alternate shall act as a member of the commission at that meeting.

Effective date.] [(8) This section shall take effect February 25, 1993.] (MCL §752.1023.)

§28.547(124) Recommendations to legislature; factors to consider.] Sec. 4. [(1)] Within 15 months after the effective date of this act, the commission shall develop and submit to the legislature recommendations as to legislation concerning the voluntary self-termination of life. In developing these recommendations, the commission shall consider each of the following:

(a) Current data concerning voluntary self-termination, including each of the following:

(i) The current self-termination rate in the state, compared with historical levels.

(ii) The causes of voluntary self-termination, and in particular each of the following:

(A) The role of alcohol and other drugs.

(B) The role of age, disease, and disability.

(iii) Past and current Michigan law concerning voluntary self-termination, including the status of persons who assist a patient's self-termination, and in particular the effect of any relevant law enacted during the 86th Legislature.

(iv) The laws of other states concerning voluntary self-termination, and in particular the effect of those laws on the rate of self-termination.

(b) The proper aims of legislation affecting voluntary self-termination, including each of the following:

(i) The existence of a societal consensus in the state on the morality of the voluntary self-termination of life, including the morality of other persons assisting a patient's self-termination.

(ii) The significance of each of the following:

(A) The attitudes of a patient's family regarding his or her voluntary self-termination.

(B) The cause of a patient's act of self-termination, including apprehension or existence of physical pain, disease, or disability.

(iii) Whether to differentiate among the following causes of voluntary self-termination:

(A) Physical conditions, as distinguished from psychological conditions.

(B) Physical conditions that will inevitably cause death, as distinguished from physical conditions with which a patient may survive indefinitely.

(C) Withdrawing or withholding medical treatment, as distinguished from administering medication, if both are in furtherance of a process of voluntary self-termination.

(iv) With respect to how the law should treat a person who assists a patient's voluntary self-termination, whether to differentiate based on the following:

(A) The nature of the assistance, including inaction; noncausal facilitation; information transmission; encouragement; providing the physical means of self-termination; active participation without immediate risk to the person assisting; and active participation that incurs immediate risk to the person assisting, such a suicide pacts.

(B) The motive of the person assisting, including compassion, fear for his or her own safety, and fear for the safety of the patient.

(C) The patient's awareness of his or her true condition, including the possibility of mistake or deception.

(v) The relevance of each of the following:

(A) The legal status of suicide.

(B) The legal status of living wills.

(C) The right to execute a durable power of attorney for health care, as provided in section 496 of the revised probate code, Act No. 642 of the Public Acts of 1978, being section 700.496 of the Michigan Compiled Laws.

(D) The common-law right of a competent adult to refuse medical care or treatment.

(E) Constitutional rights of free speech, free exercise of religion, and privacy, and constitutional prohibitions on the establishment of religion.

(c) The most efficient method of preventing voluntary self-terminations, to the extent prevention is a proper aim of legislation. In particular, the commission shall consider each of the following:

(i) The costs of various methods of preventing voluntary self-terminations, including the use of any of the following:

(A) Public health measures, such as crisis therapy and suicide counseling services.

(B) Tort law.

(C) Criminal law, including the desirability of criminalizing suicide or attempted suicide.

(D) Civil sanctions, including the denial of inheritance and requirements of community service and mandatory counseling.

(ii) The likely effect of any of the methods listed in subparagraph (i) on the self-termination rate, and in particular the probability that a particular method might cause the self-termination rate to increase.

(iii) The impact of any of the methods listed in subparagraph (i) on the practice of medicine and the availability of health care in the state.

(iv) Whether current state law is adequate to address the question of voluntary self-termination in the state.

(d) Appropriate guidelines and safeguards regarding voluntary self-terminations the law should allow, including the advisability of allowing, in limited cases, the administering of medication in furtherance of a process of voluntary self-termination.

(e) Any other factors the commission considers necessary in developing recommendations for legislation concerning the voluntary self-termination of life.

Effective date.] [(2) This section shall take effect February 25, 1993.] (MCL §752.1024.)

§28.547(125) Open meetings act; applicability.] Sec. 5. [(1)] The business of the commission shall be conducted in compliance with the open meetings act, Act No. 267 of the Public Acts of 1976, being sections 15.261 to 15.275 of the Michigan Compiled Laws.

§28.547(126) Freedom of information act; applicability; writings prepared or possessed by commission.] Sec. 6. [(1)] A writing prepared, owned, used, in the possession of, or retained by the commission in the performance of an official function shall be made available to the public in compliance with the freedom of information act, Act No. 442 of the Public Acts of 1976, being sections 15.231 to 15.246 of the Michigan Compiled Laws.

§28.547(127) Assistance to suicide; felony; penalty.] Sec. 7. (1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both:

(a) Provides the physical means by which the other person attempts or commits suicide.

(b) Participates in a physical act by which the other person attempts or commits suicide.

Exception; withholding or withdrawing medical treatment.] (2) Subsection (1) shall ◆ [not apply to withholding or withdrawing medical treatment].

Exception; medications and procedures not intended to cause death.] (3) ◆ [Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is to relieve pain or discomfort and

not to cause death, even if the medication or procedure may hasten or increase the risk of death.]

Effective date.] [(4) This section shall take effect February 25, 1993.]

Prospective repeal.] [(5)] ◆ This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4. (MCL §752.1027.)

MINNESOTA

609.215. Suicide

Subdivision 1. Aiding suicide. Whoever intentionally advises, encourages, or assists another in taking the other's own life may be sentenced to imprisonment for not more than 15 years or to payment of a fine of not more than $30,000, or both.

Subd. 2. Aiding attempted suicide. Whoever intentionally advises, encourages, or assists another who attempts but fails to take the other's own life may be sentenced to imprisonment for not more than seven years or to payment of a fine of not more than $14,000, or both.

Subd. 3. Acts or omissions not considered aiding suicide or aiding attempted suicide. (a) A health care provider, as defined in section 145B.02, subdivision 6, who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death.

(b) A health care provider, as defined in section 145B.02, subdivision 6, who withholds or withdraws a life-sustaining procedure in compliance with chapter 145B or in

accordance with reasonable medical practice does not violate this section.

Subd. 4. Injunctive relief. A cause of action for injunctive relief may be maintained against any person who is reasonably believed to be about to violate or who is in the course of violating this section by any person who is:

(1) the spouse, parent, child, or sibling of the person who would commit suicide;

(2) an heir or a beneficiary under a life insurance policy of the person who would commit suicide;

(3) a health care provider of the person who would commit suicide;

(4) a person authorized to prosecute or enforce the laws of this state; or

(5) a legally appointed guardian or conservator of the person who would have committed suicide.

Subd. 5. Civil damages. A person given standing by subdivision 4, clause (1), (2), or (5), or the person would have committed suicide, in the case of an attempt, may maintain a cause of action against any person who violates or who attempts to violate subdivision 1 or 2 for compensatory damages and punitive damages as provided in section 549.20. A person described in subdivision 4, clause (4), may maintain a cause of action against a person who violates or attempts to violate subdivision 1 or 2 for a civil penalty of up to $50,000 on behalf of the state. An action under this subdivision may be brought whether or not the plaintiff had prior knowledge of the violation or attempt.

Subd. 6. Attorney fees. Reasonable attorney fees shall be awarded to the prevailing plaintiff in a civil action brought under subdivision 4 or 5.

MISSISSIPPI

§ 97-3-49. Suicide--aiding.

A person who wilfully, or in any manner, advises, encourages, abets, or assists another person to take, or in taking, the latter's life, or in attempting to take the latter's life, is guilty of felony and, on conviction, shall be punished by imprisonment in the penitentiary not exceeding ten years, or by fine not exceeding one thousand dollars, and imprisonment in the county jail not exceeding one year.

MONTANA

45-5-105. Aiding or soliciting suicide. (1) A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide.

(2) A person convicted of the offense of aiding or soliciting a suicide shall be imprisoned in the state prison for any term not to exceed 10 years or be fined an amount not to exceed $50,000, or both.

NEBRASKA

28-307. Assisting suicide, defined; penalty. (1) A person commits assisting suicide when, with intent to assist another person in committing suicide, he aids and abets him in committing or attempting to commit suicide.

(2) Assisting suicide is a Class IV felony.

NEW HAMPSHIRE

630:4 Causing or Aiding Suicide.

I. A person is guilty of causing or aiding suicide if he purposely aids or solicits another to commit suicide.

II. Causing or aiding suicide is a class B felony if the actor's conduct causes such suicide or an attempted suicide. Otherwise it is a misdemeanor.

NEW JERSEY

2C:11-6. Aiding suicide

A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.

NEW MEXICO

30-2-4. Assisting suicide.

Assisting suicide consists of deliberately aiding another in the taking of his own life. Whoever commits assisting suicide is guilty of a fourth degree felony.

NEW YORK

§ 120.30 Promoting a suicide attempt

A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide.

Promoting a suicide attempt is a class E felony.

§ 120.35 Promoting a suicide attempt; when punishable as attempt to commit murder

A person who engages in conduct constituting both the offense of promoting a suicide attempt and the offense of attempt to commit murder may not be convicted of attempt to commit murder unless he causes or aids the suicide attempt by the use of duress or deception.

OKLAHOMA

§ 813. Aiding suicide

Every person who willfully, in any manner, advises, encourages, abets, or assists another person in taking his own life, is guilty of aiding suicide.

§ 814. Furnishing weapon or drug

Every person who willfully furnishes another person with any deadly weapon or poisonous drug, knowing that such person intends to use such weapon or drug in taking his own life, is guilty of aiding suicide, if such person thereafter employs such instrument or drug in taking his own life.

§ 815. Aid in attempt to commit suicide

Every person who willfully aids another in attempting to take his own life, in any manner which by the preceding sections [footnote omitted] would have amounted to aiding suicide if the person assisted had actually taken his own life, is guilty of aiding an attempt at suicide.

§ 816. Incapacity of person committing or attempting suicide no defense

It is no defense to a prosecution for aiding suicide or aiding an attempt at suicide, that the person who committed or attempted to commit the suicide was not a person deemed capable of committing crime.

§ 817. Punishment for aiding suicide

Every person guilty of aiding suicide is punishable by imprisonment in the penitentiary for not less than seven (7) years.

§ 818. Punishment for aiding an attempt at suicide

Every person guilty of aiding an attempt at suicide is punishable by imprisonment in the penitentiary not exceeding two (2) years, or by a fine not exceeding One Thousand Dollars ($1,000.00), or both.

OREGON

163.125 Manslaughter in the second degree

(1) Criminal homicide constitutes manslaughter in the second degree when:

. . .

(b) A person intentionally causes or aids another person to commit suicide.

PENNSYLVANIA

§ 2505. Causing or aiding suicide

. . .

(b) Aiding or soliciting suicide as an independent offense.--A person who intentionally aids or solicits another to commit suicide is guilty of a felony of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a misdemeanor of the second degree.

SOUTH DAKOTA

22-16-37. Aiding and abetting suicide as felony. Any person who intentionally in any manner advises, encourages, abets or assists another in taking his own life is guilty of a Class 6 felony.

TEXAS

§ 22.08. Aiding Suicide

(a) A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide.

(b) An offense under this section is a Class C misdemeanor unless the actor's conduct causes suicide or

attempted suicide that results in serious bodily injury, in which event the offense is a felony of the third degree.

WISCONSIN

940.12 Assisting suicide

Whoever with intent that another take his or her own life assists such person to commit suicide is guilty of a Class D felony.

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	DECLARATION OF JOHN P. GEYMAN, M.D.
Defendants.	)	

JOHN P. GEYMAN, M.D. declares:

1. I am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of California in 1960.

3. From 1976 through 1990 I served as Professor and Chairman of the Department of Family Medicine at the School of Medicine at the University of Washington. Since stepping down as Chairman of the Department, I have continued to serve as Professor of Family Medicine in the Department of Family Medicine at the School of Medicine at the University of Washington. I held privileges at the University of Washington Medical Center from 1976 to 1993. Since 1993 I have continued as Professor Emeritus of Family Medicine at the University of Washington and have returned to rural practice at the Inter-Island Medical Center, Friday Harbor, Washington.

4. I am a charter fellow of the American Academy of Family Physicians and am certified by the American Board of Family Practice.

5. In addition to my academic appointments, I have practiced family medicine in a number of different practices and places over the course of my career.

6. I am a member of the American Medical Association, the American Academy of Family Physicians, the Society of Teachers of Family Medicine, the Washington State Medical Association, the King County Medical Society, the American Association for Advancement in Science, and the Institute of Medicine.

7. I am recognized in Who's Who in Health Care, Who's Who in America, and the International Who's Who in Medicine.

8. I have published over 70 articles related to the practice of family medicine in medical journals. I have

also authored numerous books, book chapters, and monographs in the field. I am the founding editor of the Journal of Family Practice (1974-1990) and, since 1990, have served as editor of the Journal of the American Board of Family Practice.

9. My complete curriculum vitae is attached hereto.

10. In my 35 years experience as a practicing family physician and medical educator I have had many occasions to witness mentally competent, terminally ill adult patients confront issues relating to their dying process, including the issue of hastening the dying process. Over this period, I have also seen many patients endure unnecessarily prolonged pain and suffering in the dying process under circumstances where patients, for one reason or another, had insufficient participation in deciding upon their terminal care.

11. Physicians caring for patients with terminal illnesses necessarily become directly involved in assisting such patients and their families to understand the prognosis, expected course and options for either therapeutic or palliative care. In the presence of terminal illness, the shared goal of medical care at some point becomes comfort care rather than cure. The physician's task becomes one of alleviating pain and suffering as much as possible.

12. With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt. As a result, many experience prolonged deaths often involving pain, suffering and loss of dignity. In reaction to this problem, an increasing number of patients want more direct control over the type of care they receive in the last stage of their lives. A subset of dying patients desire to shorten their dying process and thereby

avoid a lingering death and associated pain, suffering and loss of dignity.

13. Terminally ill persons who seek to hasten death by consuming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. Many terminally ill persons will be taking a variety of medications for their condition; for example, patients suffering chronic pain may be taking high doses of morphine or other narcotics and may have developed a high tolerance to narcotics. Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task.

14. It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try do so without medical advice. These efforts are often unsuccessful and can cause the patient and family increased anxiety, pain and suffering. Very often, patients who survive a failed suicide attempt find themselves in worse shape than before the attempt.

15. There is often a severe adverse emotional and psychological effect on terminally ill patients who either are unable to broach the subject of their desire to hasten their death with their physician because of the current prohibition or broach the subject but are rebuffed. These patients feel abandoned by their physician when most in need of help.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Seattle, Washington, this 10th day of March, 1994.

/s/
JOHN P. GEYMAN, M.D.

CURRICULUM VITAE

John P. Geyman, M.D.

Birthdate:	February 9, 1931
Address:	4909 C Hannah Road Friday Harbor, Washington 98250
	Married 36 years 3 sons (ages 31, 32, and 33)
SSN:	562-50-0853

PRESENT POSITION:

10/01/90-Present	Professor of Family Medicine, Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington

PREVIOUS POSITIONS:

12/1/76-9/30/90	Professor and Chairman, Department of Family Medicine, School of Medicine, University of Washington, Seattle, Washington
9/1/72-11/76	Professor and Vice Chairman, Department of Family Practice, School of Medicine, University of California - Davis
9/1/72-11/76	Director, University of California - Davis, Family Practice Residency Network Program
1971-72	Chairman, Division of Family Practice, University of Utah College of Medicine, Salt Lake City, Utah

1971-72	Director, University of Utah Family Practice Residency Program, University of Utah Affiliated Hospitals for Family Practice
1969-71	Director, University of California - San Francisco, Community Hospital of Sonoma County Family Practice Program
1969-71	Project Coordinator, University of California - San Francisco, Sonoma County Demonstration Project, Regional Medical Programs (Area I)

EDUCATION:

Undergraduate:

1948-52	Princeton University, A.B. (Geology), Princeton, New Jersey
1955-56	University of California, Premedical, Berkeley, California

Medical School:

1956-60	University of California School of Medicine, M.D., San Francisco, California

Postdoctoral:

1960-61	Los Angeles County General Hospital, Rotating Internship, Los Angeles, California
1961-63	Sonoma County Hospital, General Practice Residency, Santa Rosa, California

CERTIFICATION:

1973	Charter Fellow, American Academy of Family Physicians
Since 1971	Charter Member of American Board of Family Practice (certified in February 1971, recertified in December 1977, September 1983, and October 1990)

LICENSURE:

1977-Present	(Medical)	State of Washington	No. 15618
1977-Present	(Narcotics)	State of Washington	No. AG-5331703
1961-85	(Medical)	State of California	No. A-19658
1961-85	(Narcotics)	State of California	No. 18098

PRACTICE EXPERIENCE:

1963-69	Private Practice, Solo General Practice, Mount Shasta, California
1967-69	Director, Coronary Care Unit, Mount Shasta Community Hospital
1990-Present	Part-Time Group Practice, Inter-Island Medical Center, Friday Harbor, Washington.

HOSPITAL STAFF MEMBERSHIPS:

Present:

1/1/77-Present	University of Washington Medical Center, Seattle, Washington
9/1/72-1976	Sacramento Medical Center, Sacramento, California
1963-69	Mount Shasta Community Hospital, Mount Shasta, California
1969-71	Community Hospital of Sonoma County, Santa Rosa, California

1971-72	University Hospital, University of Utah Medical Center, Salt Lake City, Utah

PROFESSIONAL ASSOCIATIONS:

1960-Present	Gold Headed Cane Society (University of California, School of Medicine, San Francisco)
1963-Present	American Medical Association
1964-Present	American Academy of Family Physicians
1969-Present	Society of Teachers of Family Medicine
1978-Present	Washington State Medical Association
1978-Present	King County Medical Society
1978-1990	Association of Departments of Family Medicine
1983-Present	American Association for Advancement of Science

OFFICES HELD:

1959-60	President, Senior Class, University of California School of Medicine
1967	President, Siskiyou County Medical Society
1968	Chief of Staff, Mount Shasta Community Hospital
1968-69	President, Siskiyou County Comprehensive Health planning Council
1969	Board of Trustees, College of Siskiyou, Weed, California

HONORS:

1960	Gold Headed Cane Award, University of California School of Medicine (San Francisco)
1974	American Men and Women of Science

1977	Who's Who in Health Care
1979	Who's Who in America
1980	Certificate of Excellence, Society of Teachers of Family Medicine
1980	Thomas W. Johnson Award for contributions in family practice education, American Academy of Family Physicians
1985	Member, Institute of Medicine, National Academy of Sciences
1986	International Who's Who in Medicine
1988	Alumnus of the Year, 1988, Community Hospital Alumni Association, Santa Rosa, California
1990	Curtis B. Hames Research Award, North America Primary Care Research Group and Society of Teachers in Family Medicine
1992	Fellow, Royal Society of Medicine, New York and London.

ACADEMIC APPOINTMENTS:

12/1/76-Present	Professor of Family Medicine, University of Washington School of Medicine
9/1/72-11/76	Professor of Family Practice, University of California Davis, School of Medicine
1971-72	Associate Professor of Community and Family Medicine, University of Utah College of Medicine
1969-71	Assistant Clinical Professor of Ambulatory and Community Medicine, University of California, San Francisco

SELECTED COMMITTEES:

University of California - Davis School of Medicine:

1972-76	Admissions Committee
1973-75	Task Force on Planning for Medical School Facilities: Subgroup on Patient Care Needs, Inland Northern California, 1980-85

California Medical Association:

1973-76	Advisory Panel on General and Family Practice

Society of Teachers of Family Medicine:

1971-75	Program Committee
1971-75	Graduate Objectives Committee
1973-78	Education Committee
1975-80	Audio-Visual Review Committee (Chairman)
1979-81	Faculty Development Task Force

University of Washington School of Medicine:

1977-1990	Medical School Executive Committee
1978-1979	Steering Committee of Executive Committee
1978-1984	Appointments and Promotions Committee
1981-1984 and	Academic Affairs Committee
1987-1990	Academic Affairs Committee
1985-1990	Ad Hoc Committee on International Educational Activities of the School of Medicine
1985-1989	Joint Conference Committee
1986-1990	Regional Affairs Committee
1986-Present	Medex Advisory Committee
1987	Chairman, Ad Hoc Committee to Consider Clinical Track

1987-1990	Finance Committee, Associated University Physicians
1987-1988	Awards and Prizes Committee
1988-1992	Admissions Committee
1989-1990	Admissions Review Task Force Committee, Dean's Office

RELATED ACTIVITIES:

1972-78	Consultant for Survey Team for Review of Physician Assistant Programs, American Medical Association
1973-79	Member of Examination Panel - Pictorial Subcommittee, American Board of Family Practice (Chairman, 1975-79)
1973-Present	Regional Consultant for Family Practice Residencies, American Academy of Family Practice
1974-76	Consultant for Family Practice Medical Education, California Health Manpower Policy Commission
1974-Present	Consultant for Family Practice Grant Program, Bureau of Health Resources Development, Department of Health, Education, and Welfare
1975-80	Consultant for Residency Assistance Program, Sponsored by American Academy of Family Physicians, American Board of Family Practice, and the Society of Teachers of Family Medicine
1981-83	Technical Advisory Committee, Financing of Graduate Medical Education Study, Department of Health and Human Services

1981-83	Member, Family Practice Board of Advisors, MULTICARE (National Group Practice Project)
1981-83	Member, Working Group on Fundamental Skills of General Physicians, Education of the Physician Project (AAMC)
1982	Member, Evaluation Committee for Stanford Medical School's Affiliated Family Practice Residency Program at San Jose Hospital
1983	Technical Advisory Committee for the National Study on Medical Care Outcomes, Robert Wood Johnson Foundation
1984	Advisory Panel for Study of Impact of Federal Support of Family Practice Residency Training, Policy Analysis, Inc., and Department of Health and Human Services
1984	Delegation Leader, Family Medicine Delegation to China, Taiwan, and South Korea, People-to-People Citizen Ambassador Program
11/15/85-12/15/85	Visiting Professor, Beer Sheva Medical School, Israel
1986	Delegation Leader, Family Medicine Delegation to Sweden, Soviet Union, and Norway, People-to-People Citizen Ambassador Program
1985-Present	Member, Evaluation Steering Committee for Physician Data Query (PDQ) Projects, National Cancer Institute

1986	Dean's Advisory Committee for Review of Department of Family Medicine, University of California, Irvine
1986-88	Membership Committee, Institute of Medicine
1987-Present	Ad Hoc Committee on Funding for Family Practice, Society of Teachers of Family Medicine
1988	Dean's Advisory Committee for Review of Department of Family Practice and Community Health, University of Minnesota
1988-1989	Study Group for Strategies for Supporting Graduate Medical Education in Primary Care, Institute of Medicine
1988-Present	Chairman, Ad Hoc Committee to Consider Organizational Options for Academic Family Medicine, Society of Teachers of Family Medicine and Association of Departments of Family Medicine.
1989	Invited Participant at Conference on the Future of the Generalist Physician in America, Boston, Massachusetts. Josiah Macy, Jr. Foundation.
1989-1990	Member, Board of Inter-Island Medical Center, Friday Harbor, Washington
1990	External reviewer for Department of Family and Preventive Medicine, University of Utah

1990-Present	Member, Clinical Science Committee of Association of American Medical Colleges for Selection of Distinguished Teacher Awards
1990	Invited as Panel Participant, International Family Practice Panel to select candidates for international academic positions, Faculty of Medicine, United Arab Emirates University, United Arab Emirates
1990-Present	Member, Departments of Family Medicine Review Committee, Division of Medicine, Health Resources & Services Administration, to review grant applications. Rockville, Maryland.
1991	Member, Editorial Advisory Board for Family Physicians Anxiety Education, Program, Science and Medicine, New York
1991	Invited Participant, AAMC Focus Group on Graduate Medical Education for Primary Care, Washington, D.C.
1991	Visiting Professor, University of Oregon Health Sciences Center, Portland, Oregon
1991	Invited Participant, AAMC Focus Group on Graduate Medical Education for Primary Care, Washington, D.C.
1991-1992	Member, Rural Health System Development Project Review Committee, State of Washington, Department of Health.

1992 Member, Education Committee for Statewide Health Personnel Resource Plan, State of Washington Higher Education Coordinating Board.

1992 Visiting Professor, National Taiwan University, Taipei, Taiwan, Republic of China.

1992 Visiting Professor, University of Nevada, Reno, Nevada.

EXTRA-MURAL GRANTS:

Principal Investigator, University of California Davis Family Practice Residency Program in Affiliated Hospitals for Family Practice, funded by W. K. Kellogg Foundation
(7/1/73-6/30/77: $417,164)

Project Investigator, Health Professions Special Project Grant for Preceptorship Training, funded by Department of Health, Education and Welfare, Public Health Service, National Institute of Health
(3/1/74-6/30/76: $543,306)

Principal Investigator, Family Practice Residency Training Program, University of California Davis, Sacramento Medical Center, and Affiliated Hospitals for Family Practice, funded by Department of Health, Education and Welfare, Public Health Service, National Institute of Health
(4/1/74-6/30/76: $302,653)
Supplemental Grants(4/1/74-6/30/75: $55,437) and
(7/1/75-6/30/76: $114,785)

Principal investigator, University of California Davis Family Practice Residency Program Expansion of University-Based Program involving Davis Family Practice Center, Merced Community Medical Center, and Shasta Cascade Family Practice Residency, funded by Health

Manpower Policy Commission, State of California
(7/1/75-6/30/79: $813,261)

Principal Investigator, Family Practice Residency Network Grant involving University of Washington Hospital and six affiliated hospitals with Family Medicine training programs; funded by the W. K. Kellogg Foundation
(12/1/76-8/30/82: $929,821)

Principal Investigator, Family Medicine Residency Network Training Grant involving University of Washington Hospital and six affiliated hospitals for Family Medicine, funded by Department of Health, Education and Welfare, Public Health Service
(7/1/77-6/30/80: $740,000)

Co-Investigator, Faculty Fellowship in Family Medicine, funded by the Robert Wood Johnson Foundation
(1/1/78-6/30/81: $623,832)
Renewal Grant: (7/1/81-6/30/84: $737,498)

Principal Investigator, Family Medicine Residency Training involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/80-6/30/85: $713,000)

Principal Investigator, renewal of the Faculty Fellowship in Family Medicine, funded by the Robert Wood Johnson Foundation
(7/1/84-6/30/87: $1,219,103)

Co-Principal Investigator, The Rural Hospital Project to devise model rural hospital service configurations for six rural hospitals in the WAMI region, funded by the W. K. Kellogg Foundation
(12/1/83-11/30/87: $1,268,827)

Principal Investigator, Supplemental Grant for University Hospital Family Medicine Residency Program, funded by

Department of Health and Human Services, Public Health Service
(7/1/85-6/30/85: $54,862)

Principal Investigator, Family Medicine Residency Training Grant involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/85-6/30/88: $580,139)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Department of Health and Human Services, Public Health Service
(9/1/86-8/31/89: $427,634)

Principal Investigator, Family Medicine Residency Training Grant involving University of Washington Hospital, funded by Department of Health and Human Services, Public Health Service
(7/1/88-6/30/91: $345,000)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Department of Health and Human Services, Public Health Service
(9/1/89-8/31/92: $534,021)

Principal Investigator, Department of Family Medicine Grant, University of Washington, funded by Lutheran Health Systems, Fargo, North Dakota, and Northwest Area Foundation, St. Paul, Minnesota
(9/1/91-8/31/94: $300,000)

SELECTED PRESENTATIONS:

3/73 "Obstetrics and Family Practice: Conflict in Medical Education?" Annual Meeting of Association of Professors of Obstetrics and Gynecology, New Orleans, Louisiana

7/73 "The Model Family Practice Unit in a University Program." Fifth Annual Workshop for Developing Programs in Family Practice, Kansas City, Missouri

11/74 "Methods of Continuing Education for the Practicing Physician." Sixth World Conference on General Practice and Family Medicine, Mexico City, Mexico

6/75 "The Practicing Family Physician as a Student and Teacher." Workshop for Directors of Family Practice Residencies, Kansas City, Missouri

3/76 "Goals and Objectives of a Family Practice Residency Training Program." 1976 Annual Workshop for Developing Programs in Family Practice, American Academy of Family Physicians, Kansas City, Missouri

3/77 "Perceptions of Formal In-Training Evaluation by Family Practice and Internal Medicine Residents." North American Primary Care Research Group, Richmond, Virginia

3/77 "Regionalized Family Medicine Residency Programs." Thirtieth National Conference on Rural Health, Seattle, Washington

5/78 "Meet the Editors." U.S. Representative to WONCA Meeting (Eighth World Conference on Family Medicine/General Practice), Montreux, Switzerland

4/79 "Research in Primary Care." Annual Meeting of North American Primary Care Research Group, Seattle, Washington

5/79 "Graduate Education in Family Practice: A Ten-Year View." Annual Meeting of Society of Teachers of Family Medicine, Denver, Colorado

4/80 "Goals for Family Practice in 1990." State University of New York, Stony Brook, New York

11/80 "Family Practice - Then and Now." George Firestone, M.D., Memorial Lecture, University of California, School of Medicine, Santa Rosa, California

5/81 "Behavioral Science and Family Medicine: Theory and Practice." Association for Behavioral Science and Medical Education, Quinault, Washington

11/81 "Evaluation of Teaching Performance in Family Medicine." Association of Departments of Family Medicine, Washington, D.C.

11/81 "Career Tracks in Academic Family Medicine: Problems and Approaches." Society of Teachers of Family Medicine, Asilomar, California

5/83 "Treatment of Mild Hypertension." "An Editor's View of the Peer Review Process." Annual Meeting of Royal College of General Practitioners, Dunedin, New Zealand

5/83 "Family Practice Journals and Information Needs in Family Practice." Tenth WONCA World Conference on Family Medicine, Singapore

10/83 "Relevance of Tenure to the Career of a Family Physician." Western Regional Meeting of Society of Teachers of Family Medicine, Long Beach, Washington

9/84 "Teaching Continuity of Care in Family Practice." Western Regional Meeting of Society of Teachers of Family Medicine, Seattle, Washington

9/84 "Journals for Family Practice." Advanced Forum in Family Medicine, Keystone, Colorado

7/85 "Evolution of the Family Practice Residency." Third Family Medicine Seminar, Nikko, Japan

11/85 "The Family Physician as a Specialist in the Medical Education System." Greek-USA Family Practice Symposium

12/85 "Changing Trends in Primary Care and Family Medicine." Ben Gurion University of the Negev, Hebrew University and University of Tel-Aviv, Israel

5/86 "Primary Medicine for the 21st Century: What Are the Options?" Eighth Annual Meeting of Robert Wood Johnson Foundation's Family Practice Fellowship Programs, San Diego, California

11/86 "Future Trends in Primary Care and Family Practice." Keynote Address, Research Day X, Michigan State University, Lansing, Michigan

4/87 "Interface of General Internal Medicine and Family Medicine." Annual Meeting of Society for Research and Education in Primary Care Internal Medicine, San Diego, California

9/88 "Beyond the Plateau: Alternative Future Scenarios for Family Practice and Primary Care." Advanced Forum in Family Medicine, Keystone, Colorado

11/88 "Future Directions for Departments of Family Medicine." Meeting of Association of Departments of Family Medicine, Chicago, Illinois

12/88 "Research, the Literature, and Family Medicine as an Academic Discipline." Third Annual Primary Care Research Methods and Statistics Conference, University of Texas, San Antonio

4/89 "Options for Training Generalist Physicians for 21st Century." Endicott House, Cambridge. Josiah Macy Jr. Foundation

5/89 "General Issues in Medicare Financing of Family Practice and Primary Care Residencies." Society of Teachers of Family Medicine, Denver, Colorado

10/89 "Organizational Alternatives for Academic Family Medicine." Meeting of Association of Departments of Family Medicine. Washington, D.C.

2/90 "The Department of Family Medicine and the Area Health Education Center." Meeting of Association of Departments of Family Medicine, Palm Springs, California

5/90 "Family Medicine as an Academic Discipline: Progress, Challenges, and Opportunities." Society of Teachers of Family Medicine, Seattle, Washington

2/91 "Planning for the Future of a Department of Family Medicine." Meeting of Association of Departments of Family Medicine. Tampa, Florida

10/91 "Family Practice in Evolution: Reflections on Change." Second Annual B. Leslie Huffman Lecture, Medical College of Ohio, Toledo, Ohio

3/92 "Family Practice in Evolution: Progress and Lessons from Initial Experience." Annual Meeting of Chinese Taipei Association of Family Medicine, Taipei, Taiwan

4/92 "Common Mistakes in Writing a Journal Article:, Meeting of the Society of Teachers of Family Medicine, St. Louis, Missouri

7/92 "Family Practice: Then and Now", Department of Family Medicine, University of Nevada, Reno

1/93 Editors' Roundtable, Third Primary Care Research Conference, Agency for Health Care Policy and Research, Atlanta, Georgia

JOURNAL ARTICLES:

1. Geyman JP: Osteogenesis imperfecta and pregnancy. Calif Med 107:171-172, August 1967
2. Geyman JP: A coronary care unit in a 25-bed rural hospital. Calif Med 112:74-77, 1970
3. Geyman JP: Sonoma county hospital residency program. California GP, pp 13-18, January/February 1970
4. Geyman JP: Acute iliofemoral thrombophlebitis during pregnancy case report. Clinical Medicine 77:21-23, November 1970
5. Geyman JP: Anaphylactic reaction to oral penicillin. Calif Med 114:87-89, May 1971
6. Geyman JP: Conversion of the general practice residency to family practice. JAMA 215:1801-1807, March 1971
7. Geyman JP: Family practice and the medical school. California GP, pp 8-14, March/April 1971
8. Geyman JP: The University of Utah Division of Family Practice goals and early directions. Utah Family Physician, pp 30-36, Summer 1971
9. Geyman JP: Family medicine as an academic discipline. J Med Educ 46:815-820, October 1971
10. Geyman JP: A modular basis of resident training for family practice. J Med Educ 47:292-293, April 1972
11. Geyman JP: The new family practice residencies. California GP, pp 7-10, July/August 1973
12. Geyman JP: Obstetrics and family practice: Conflict in medical education? J Reprod Med 12(2):59-63, 1974

13. Geyman JP: A competency-based curriculum as an organizing framework in family practice residencies. J Fam Pract 1(1):34-38, 1974

14. Burr BD, Bonanno JA, Geyman JP, et al: Cardiac surgery for congenital heart disease in a multi-problem family. J Fam Pract 1(1):64-69, 1974

15. Geyman JP: Family practice residencies in community hospitals. Supplement to Am Fam Physician, pp 1-9, July 1974

16. Geyman JP, Guyton R: Evaluation of multimedia self-teaching programs for medical students taking community preceptorships. J Med Educ 49:1062-1064, 1974

17. Geyman JP, Brown TC: A developing regional network residency program in family practice. West J Med 121:514-520, 1974

18. Geyman JP: A new look at continuing education in family practice. J Fam Pract 2(2):119-122, 1975

19. Geyman JP, Brown TC: A teaching bank of audio-visual materials in family practice. J Fam Pract 2(5):359-363, 1975

20. Geyman JP: Continuity of care in family practice: Implementing continuity in a family practice residency program. J Fam Pract 2(6):445-447, 1975

21. Geyman JP, Brown TC, Ribers K: Referrals in family practice: A comparative study by geographic region and practice setting. J Fam Pract 3(2):163-167, 1976

22. Geyman JP: Continuing medical education in a family practice residency. California GP, pp 10-12, May/June 1976

23. Geyman JP, Brown TC: An in-training examination for residents in family practice: A pilot study. J Fam Pract 3(4):409-413, 1976

24. Geyman JP: Evaluating family practice residencies. The New Physician 25(9):35-37, 1976

25. Geyman JP, Brown TC: A network model for decentralized family practice residency training. J Fam Pract 3(6):621-627, 1976

26. Geyman JP: The practicing family physician as a teacher and learner in a family practice residency. AHME Journal, 30-31, January 1977

27. Geyman JP: The "one-and-two" family practice residency program, Supplement to Am Fam Physician, February 1977

28. Geyman JP: Phase two of the University of Washington Department of Family Medicine. Washington Family Physician, 6-10, Spring 1977

29. Geyman, JP, Brown TC: Evaluation of audiovisual teaching materials in family practice: A report of review activities 1974-76. J Fam Pract 4(5):903:918, 1977

30. Geyman JP: Prevention of complications in initial development of family practice residency programs. J Fam Pract 4(6): 1111-1115, 1977

31. Leaman TL, Geyman JP, Brown TC: Graduate education in family practice. J Fam Pract 5(1):47-61, 1977

32. Geyman JP: Research in the family practice residency program. J Fam Pract 5(2):245-248, 1977

33. Geyman JP: Recent developments and future directions in family practice. University of Washington Medicine 4(3): 17-24, Fall, 1977

34. Geyman JP: The family as the object of care. J Fam Pract 5(4):571-575, 1977. Reprinted in South Dakota J of Med XXXI(4):29-34, April 1978

35. Geyman JP, Brown TC, Lee P: Perceptions of formal in-training evaluation by family practice residents. J Fam Pract 5(5):869-870, 1977

36. Geyman JP: The "one-and-two" program: A new direction in family practice residency training. J Med Educ 52:999-1001, 1977

37. Geyman JP: Family practice in evolution: Progress, problems and projections. N Engl J Med 298:593-601, 1978

38. English EC, Geyman JP: The efficiency and cost-effectiveness of diagnostic tests for infectious mononucleosis. J Fam Pract 6(5):977-981, 1978

39. Shortell SM, Dowling WL, Foster R, Urban N, Williams SJ, Geyman JP, Phillips TJ, Richardson WC, and Ross A: Hospital-sponsored primary care: Organizational and financial issues. Medical Group Management 25(3):16-22, May/June 1978

40. Geyman JP: Climate for research in family practice. J Fam Pract 7(1):69-74, 1978

41. Geyman JP, Bass MJ: Communication of results of research. J Fam Pract 7(1):113-120, 1978

42. Geyman JP, Deisher JB, Gordon MJ: A family practice residency network: Affiliated programs in the Pacific Northwest. JAMA 240(4):369-371, 1978

43. Geyman JP, Erickson S: The ampicillin rash as a diagnostic and management problem: Case reports and literature review. J Fam Pract 7(3):493-496, 1978

44. Geyman JP, Gordon MJ: Orthopedic problems in family practice: Incidence, distribution and curricular implications. J Fam Pract 8(4):759-765, 1978

45. Geyman JP: Family practice in the United States: The first ten years, J Royal Coll Gen Pract 29:289-296, 1979

46. Geyman JP: Evaluation of audiovisual teaching materials in family practice: A report of review activities, 1977-1978. J Fam Pract 8(5):985-1001, 1978

47. Geyman JP: Family Practice finds a home in the hospital. Hosp Med Staff 8(10):14-20, 1979

48. Geyman JP: The Department of Family Medicine at the University of Washington: A progress report. The Washington Family Physician 6(4):6-9, 1979

49. Geyman JP: Graduate education in family practice: A ten-year view. J Fam Pract 9(5):859-871, 1979

50. Geyman JP: A specialty-specific approach to appraisal of audiovisual teaching materials. J Med Educ 54(12):950-952, 1979

51. Geyman JP, Cherkin DC, Deisher JB, Gordon MJ: Graduate follow-up in the University of Washington Family Practice Residency Network. J Fam Pract 11(5):743-752, 1980

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THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	JOINT MOTION FOR ENTRY OF FINAL JUDGMENT
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

The parties jointly move the court, pursuant to Fed. R. Civ. P. 54(b), to determine that there is no just reason for delaying entry of a final judgment as to those claims

addressed in the Court's Order Granting in Part and Denying in Part Plaintiffs' Motion for Summary Judgment and Denying Defendant's Cross-Motion for Summary Judgment, and to direct entry of a final judgment as to those claims. This motion is based on the Stipulation of the Parties Regarding Finality of the Court's Order and Appeal, and the parties Joint Memorandum in Support of Rule 54(b) Entry of Final Judgment, both of which are filed herewith, and is intended to facilitate an expeditious appeal of the Court's order by the defendants.

DATED this 19th day of May, 1994.

CHRISTINE O. GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire,
Attorney General

PERKINS COIE

/s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	STIPULATION OF THE PARTIES REGARDING FINALITY OF COURT'S ORDER AND APPEAL
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

The parties stipulate as follows:

1. Defendants intend to pursue an appeal of the Court's order granting partial summary judgment. It is in the best interest of all of the parties, and of the public, that such an appeal be pursued as expeditiously as possible.

2. If the Court enters a final judgment as to those claims addressed in the Order dated May 3, 1994, granting partial summary judgment as to some of plaintiffs' claims, any further action with respect to any remaining claims of the plaintiffs shall be deferred pending final resolution of the defendants' appeal of the Court's order granting partial summary judgment. This does not preclude the possibility that plaintiffs may pursue injunctive relief should events develop that warrant doing so.

3. Any petition by plaintiff for attorneys' fees shall be deferred pending final resolution of the defendants' appeal of the Court's order granting partial summary judgment.

4. This stipulation is for the purpose of facilitating appellate review of the Court's order granting partial summary judgment. By signing this stipulation, the parties shall not be deemed to have waived or in any way limited their respective legal arguments in this case.

DATED this 19th day of May, 1994.

CHRISTINE O. GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire,
Attorney General

PERKINS COIE

/s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

THE HONORABLE BARBARA J. ROTHSTEIN

FILED/ENTERED
MAY 20 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

LODGED
MAY 19 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NO. C94-119
Plaintiffs,	)	ORDER ENTERING FINAL JUDGMENT
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

IT IS HEREBY ORDERED that judgment be entered forthwith as to the claims resolved by the May 3, 1994 decision of this Court, and the clerk is directed to enter such judgment.

It is expressly determined by this Court that there is no just reason for delay in the entry of final judgment until final determination of all the issues involved in the above-entitled action.

DATED this 20th day of May, 1994.

/s/
Honorable Barbara J. Rothstein
United States District Court Judge

Presented by:

PERKINS COIE

By: /s/
Kathryn L. Tucker
David J. Burman
Thomas L. Boeder
Attorneys for Plaintiffs

CHRISTINE O. GREGOIRE
ATTORNEY GENERAL

By:_____/s/_____
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of Washington
and Christine O. Gregoire, Attorney
General of Washington

The parties' joint motion to shorten time is hereby GRANTED. [initials BJR]

THE HONORABLE BARBARA J. ROTHSTEIN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

File Number C94-119

COMPASSION IN DYING, a Washington nonprofit corporation, JANE ROE, JOHN DOE, JAMES POE, HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,	)	NOTICE OF APPEAL
Plaintiffs,	)	
vs.	)	
THE STATE OF WASHINGTON and CHRISTINE GREGOIRE, Attorney General of Washington,	)	
Defendants.	)	

FILED MAIL
MAY 20 1994
AT SEATTLE
CLERK, U.S. DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
BY DEPUTY

ENTERED
ON DOCKET
JUN 01 1994
By Deputy MG

Notice is hereby given that the State of Washington and Christine Gregoire, Attorney General of Washington, defendants, in the above named case, hereby appeal to the United States Court of Appeals for the Ninth Circuit from the judgment entered in this action on May 20, 1994.

DATED this 24th day of May, 1994.

CHRISTINE GREGOIRE
Attorney General

/s/
William L. Williams
Senior Assistant Attorney General
Attorneys for the State of
Washington and Christine O.
Gregoire, Attorney General

(8)

No. 96-110

Supreme Court, U.S.
FILED
NOV 12 1996
CLERK

IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONERS

CHRISTINE O. GREGOIRE
Attorney General

*WILLIAM L. WILLIAMS
Sr. Assistant Attorney General
WILLIAM BERGGREN COLLINS
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7+pp

QUESTIONS PRESENTED

1. Is there a constitutionally protected liberty interest under the Due Process Clause of the Fourteenth Amendment in committing suicide, and if so, does that interest include assistance in so doing?

2. If the answer to the foregoing question is in the affirmative, is a State statute that infringes on the protected liberty interest by prohibiting one person from assisting another to commit suicide nonetheless valid under the Due Process Clause because it furthers legitimate State interests?

3. Is there a rational basis for distinguishing between refusing life-sustaining medical treatment and requesting life-ending medical intervention, so that a State whose law allows the former but not the latter does not violate the Equal Protection Clause of the Fourteenth Amendment?

LIST OF PARTIES

The parties to the proceeding below were:

Petitioners: State of Washington and Christine O. Gregoire, Attorney General of Washington, both of whom were aligned as defendants/appellants below.

Respondents: Harold Glucksberg, M.D., Abigail Halperin, M.D., Thomas A. Preston, M.D., and Peter Shalit, M.D., Ph.D., all of whom were aligned as plaintiffs/respondents below. Three individuals identified only by pseudonyms were plaintiffs in the District Court below, but died during the pendency of the proceedings and are no longer parties to the litigation. A nonprofit corporation, Compassion in Dying, was a plaintiff in the District Court; however, its claims were not adjudicated by the District Court order that prompted this appeal and it is not a party to the appeal.

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I. OPINIONS BELOW

The decision of the *en banc* panel of the United States Court of Appeals for the Ninth Circuit[1] is reported at 79 F.3d 790 (9th Cir. 1996). The Court's Amended Order[2] denying a request that the full court rehear the case *en banc*, with dissenting opinions, is reported at 85 F.3d 1440 (9th Cir. 1996). The decision of the Ninth Circuit three judge panel[3] is reported at 49 F.3d 586 (9th Cir. 1995). The decision of the United States District Court for the Western District of Washington[4] is reported at 850 F. Supp. 1454 (W.D. Wash. 1994).

II. JURISDICTION

The Court of Appeals' opinion was filed and judgment entered on March 6, 1996.[5] The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1). By order of May 14, 1996, the time for filing an application for a writ of certiorari was extended to July 4, 1996.[6] The Petition For a Writ of Certiorari was filed on July 3, 1996, and was granted on October 1, 1996. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

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[1] *Compassion in Dying* II, App. Pet. Cert. at A-1 to A-164. The copy of the opinion reflects changes pursuant to the *en banc* panel's order amending the opinion filed May 28, 1996. A copy of this order is found in App. Pet. Cert. at B-1.

[2] App. Pet. Cert. at C-1 to C-26.

[3] *Compassion in Dying* I, App. Pet. Cert. at D-1 to D-27.

[4] App. Pet. Cert. at E-1 to E-29.

[5] App. Pet. Cert. at A-1.

[6] App. Pet. Cert. at F-1 to F-2.

III. CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

U.S. Constitution, Fourteenth Amendment

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Declaratory Judgment Act, 28 U.S.C. § 2201

(a) In a case of actual controversy within its jurisdiction, except with respect to Federal taxes other than actions brought under section 7428 of the Internal Revenue Code of 1986, a proceeding under section 505 or 1146 of title 11, or in any civil action involving an antidumping or countervailing duty proceeding regarding a class or kind of merchandise of a free trade area country (as defined in section 516A(f)(10) of the Tariff Act of 1930), as determined by the administering authority, any court of the United States, upon the filing of an appropriate pleading, may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought. Any such declaration shall have the force and effect of a final judgment or decree and shall be reviewable as such.

(b) For limitations on actions brought with respect to drug patents see section 505 or 512 of the Federal Food, Drug, and Cosmetic Act.

Washington Revised Code § 9A.36.060

(1) A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide.

(2) Promoting a suicide attempt is a class C felony.

Natural Death Act

Pursuant to Sup. Ct. Rule 24.1(f), the pertinent provisions of Wash. Rev. Code Ch. 70.122, the Natural Death Act, are set forth in the appendix to this brief.

IV. STATEMENT OF THE CASE

A. The Parties And Their Interests

Petitioners are the State of Washington and its Attorney General. They invoke the appellate jurisdiction of this Court to preserve and protect the ability of the people of Washington to determine an important question of public policy—whether Washington law should allow one person to knowingly aid another person to commit suicide.

Respondents are physicians who practice in Washington. J.A. at 5-7. They occasionally treat patients who they believe have no hope of survival. *Id.* Some of those patients have in the past requested that Respondents assist them to commit suicide. *Id.* Respondents' personal ethics would allow them to comply with such requests if received from future patients. *Id.*[7] However, they allege that they are deterred from doing so by Wash. Rev. Code

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[7] Regardless of Respondents' personal sense of ethics, prescribing medication other than for a therapeutic purpose violates state medical licensing standards (*see* Wash. Rev. Code § 18.130.180(6)) and is inconsistent with standards of medical ethics established by the American Medical Association. J.A. at 133-167.

§ 9A.36.060, Washington's statute prohibiting one person from assisting another to commit suicide. *Id.*

Respondents, along with three other individuals and a non-profit corporation, filed suit pursuant to 28 U.S.C. § 2201 and 42 U.S.C. § 1983 seeking a declaratory judgment that Washington's criminal statute prohibiting one person from aiding another person to commit suicide violates the rights of competent, terminally ill individuals under the Fourteenth Amendment of the United States Constitution. Plaintiffs also sought to enjoin enforcement of the statute.[8]

B. The State Statute At Issue

Washington's statute prohibiting one person from assisting another person to commit suicide was initially adopted in 1854 by the first Territorial Legislature. The prohibition has remained in effect throughout the State's history, although the specific language of the statute has varied with different codifications of the State's criminal code.[9]

The 1975 revision of the criminal code retained the prohibition against assisted suicide while at the same time it removed the criminal penalties from the act of attempting

[8] The complaint alleged that the statute violates Respondents' constitutional rights as well. J.A. at 7. These claims were neither argued to the District Court nor resolved by the District Court's order granting partial summary judgment (App. Pet. Cert. at E-28) and accordingly are not before this Court.

[9] Copies of the various legislative enactments, including the statute currently in effect, are found in App. Pet. Cert. at G-1 to G-3.

suicide.[10] The legislative committee whose comprehensive study led to the revision explained:

> "[W]hatever may be said of suicide itself, it seems clear that the introduction into the situation of another person who actively promotes the suicide could well increase the instability or irrationality of the potential suicide, affecting his judgment or emotional outlook. . . . Whatever the thoughts of a potential suicide may be, it is almost inconceivable that the threat of a two year prison sentence if he is unsuccessful in his attempt is going to deter his act. Moreover, it seems clear that such a person is in all probability a troubled, disturbed human being who need[s] psychiatric care or some other counseling service. His condition could only be aggravated by being branded a convicted felon and sent to [prison] for two years. Thus no attempted suicide crime is defined by this [proposed] code."[11]

In 1991, Washington's voters rejected Initiative 119, which, had it passed, would have authorized a form of physician aid in dying.[12] Its enactment also would have presumably created an implied exception to the crime of promoting or aiding a suicide, at least for conduct

[10] *See* 1975 Wash. Laws, 1st Ex. Sess., ch. 249, § 9A.92.010 (214) (repealing former Wash. Rev. Code § 9.80.020, which was originally enacted by 1909 Wash. Laws, ch. 249, § 134).

[11] Legislative Council's Judiciary Committee, *Report on the Revised Washington Criminal Code* 153 (Dec. 3, 1970).

[12] A copy of the initiative is found in App. Pet. Cert. at H-1 to H-10. The initiative was prepared in standard legislative drafting form, reflecting changes in then existing statutory language by underlining language to be added and striking language to be deleted, enclosing the latter in double parentheses.

explicitly authorized by the initiative. The initiative did not expressly amend or repeal the assisted suicide statute at issue here.

Almost all other States also prohibit assisting a suicide, either by statute or by case law.[13] These statutes—generally considered part of the States' homicide laws—have been recognized by this Court as evidencing the States' interest in protecting and preserving human life.[14]

C. The Proceedings Below

1. The District Court Opinion

On cross motions for partial summary judgment[15], the District Court held that "a competent, terminally ill adult has a constitutionally guaranteed right under the Fourteenth Amendment to commit physician-assisted

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[13] In his dissent from the *en banc* panel decision, Judge Beezer catalogued forty-four States that condemn assisted suicide. *See* App. Pet. Cert. at A-135 to A-136 nn.10-13. The list is extensive, but not exhaustive, because States are continuing to grapple with the issue. Judge Beezer's list does not include, for example, the 1995 Louisiana statute prohibiting "criminal assistance to suicide." *See* La. Rev. Stat. § 14:32.12 (1995 La. Acts, No. 384, § 1). It should also be noted that the Model Penal Code includes a prohibition against aiding suicide. Model Penal Code § 210.5. The Model Penal Code provision and copies of several States' statutes were appended to Petitioners' brief in the District Court and are found in J.A. at 168-86.

[14] *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 280 (1990).

[15] Respondents moved for summary judgment. J.A. at 128-29. In response, Petitioners argued that there were no genuine issues of material fact but that they were entitled to judgment as a matter of law, and that the Court should therefore enter summary judgment for them. *See Cool Fuel v. Conett*, 685 F.2d 309, 311 (9th Cir. 1982). The District Court proceeded as though both parties had in fact moved for summary judgment. App. Pet. Cert. at E-2.

suicide." App. Pet. Cert. at E-16. Finding that Washington's statute prohibiting assisted suicide places an "undue burden" on the exercise of that right, the District Court concluded that the statute violates the Due Process Clause of the Fourteenth Amendment. *Id.* at E-24.

The District Court also held that persons who depend on life support systems to remain alive are situated similarly to those who are terminally ill but able to continue living without life support, and that the refusal or withdrawal of life support by the former is "equivalent" to assisted suicide. *Id.* at E-28. The District Court concluded that by allowing withdrawal or withholding of life support, but prohibiting assisted suicide, Washington law violates the Equal Protection Clause as well. *Id.* Based on these conclusions, the District Court declared the statute unconstitutional. *Id.* at E-28 to E-29.

The District Court granted final judgment declaring the statute invalid pursuant to Fed. R. Civ. P. 54(b) and 28 U.S.C. § 2201, addressing only the claims of the patient plaintiffs and those advanced on their behalf by the physician plaintiffs. *Id.* at I-1 to I-3. The District Court did not reach the claims of the nonprofit corporation, nor the claims of the physicians on their own behalf, as they were not argued to the District Court. *Id.* at E-28. The District Court declined to grant injunctive relief. *Id.* at E-29.

2. The Court Of Appeals Panel Decision

Petitioners appealed to the Court of Appeals pursuant to 28 U.S.C. § 1291. A majority of a three judge panel of the Court of Appeals reversed the District Court, finding that the "decision of the district court lacks foundation in recent precedent [and] in the traditions of our nation." *Compassion in Dying* I, App. Pet. Cert. at D-13. Even assuming the existence of a liberty interest, the panel recognized several State interests furthered by the statute and concluded that "Washington's interests . . .

individually and convergently, outweigh any alleged liberty of suicide." *Id.* at D-14.

Rejecting the District Court's equal protection analysis, the panel also held that "plaintiffs have not sustained [their] burden" (*id.* at D-19) of demonstrating that there is no rational basis for Washington's statutory distinction "between actions taking life and actions by which life is not supported." *Id.* at D-18. Senior Judge Wright dissented. *Id.* at D-20 to D-27.

3. *En Banc* Review

Respondents' suggestion for *en banc* review was granted[16] and a limited *en banc* panel was convened pursuant to 28 U.S.C. § 46(c) and Ninth Circuit Rule 35-3. Following oral argument, a majority of the *en banc* panel "clarified" the scope of the District Court opinion and then affirmed. *Id.* at A-19. Rather than declaring the entire statute invalid, the *en banc* panel held "that the 'or aids' provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment." *Id.* at A-19 to A-20.

Three judges dissented. Judge Beezer concluded that mentally competent, terminally ill adults have a liberty interest in committing physician-assisted suicide, but that the State's interests "are sufficiently strong to sustain the constitutionality of RCW 9A.36.060 as applied to plaintiffs' asserted liberty interest." *Id.* at A-160. Judges Fernandez and Kleinfeld, in separate opinions, concurred with Judge Beezer, but added that they found no constitutionally

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[16] *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995).

protected interest in committing suicide. *Id.* at A-160 (Fernandez, J., dissenting), A-161 to A-164 (Kleinfeld, J., dissenting).

4. Post-Decision Proceedings

A *sua sponte* suggestion by an active judge of the Ninth Circuit for rehearing before the full Ninth Circuit Court failed to receive a majority of the votes of the non-recused active judges. *Id.* at C-1 to C-2. Pursuant to orders of this Court, the Ninth Circuit's mandate has been stayed pending "the sending down of the judgment of this Court." *Id.* at K-1. The Petition For Writ Of Certiorari was filed on July 3, 1996, and granted on October 1, 1996. *Washington v. Glucksberg*, 117 S. Ct. 37 (1996).

V. SUMMARY OF ARGUMENT

The clear line between permitting refusal of treatment and prohibiting action intended to cause death is based on well-settled legal doctrines. Whether that line should be disturbed to allow physician-assisted suicide is a complex and controversial issue of public policy which is vigorously debated throughout the land. State legislatures should be allowed to resolve the issue without having their policy choices limited.

The decision below is a radical departure from our nation's legal traditions and this Court's Fourteenth Amendment jurisprudence. Disregarding this Court's restrained analytical approach to substantive due process claims, the Ninth Circuit created a protected interest that is not rooted in our historical concepts of liberty and is different in character and quality from other protected liberty interests recognized by this Court. In addition, the balancing test used by the Ninth Circuit undervalued legitimate State interests that are furthered by the statute at issue.

Moreover, this Court should reject the Ninth Circuit's "as applied" approach to substantive due process claims which focused on hypothetical subsets of the population rather than the needs of society as a whole. If upheld, this approach trumpets a new and intrusive role for the federal judiciary in evaluating the policy judgments of State legislatures and voters.

Washington law does not violate the Equal Protection Clause because those who require mechanical assistance to eat, breathe, and drink are situated differently from those who do not, and the line allowing the former to refuse artificial life support while prohibiting assisted suicide to everyone else is rationally based on these well-settled differences and equally well-settled legal doctrines.

Additionally, there is no principled basis on which the asserted right to assisted suicide can be limited to physician prescription of medication for mentally competent, terminally ill patients to administer to themselves. This Court should decline the invitation to resolve by Constitutional mandate the public policy debate over whether physician-assisted suicide should be allowed.

VI. ARGUMENT

A. The Clear Line Between Permitting Refusal Of Treatment And Prohibiting Action Intended To Cause Death Is Based On Well-Settled Legal Doctrines. Whether That Line Should Be Disturbed To Allow Physician-Assisted Suicide Is A Complex And Controversial Issue Of Public Policy Which Is Vigorously Debated Throughout The Land. State Legislatures Should Be Allowed To Resolve The Issue Without Having Their Policy Choices Limited

This case lies at the intersection of two well-established doctrines in our legal traditions. The first holds

that each of us has the right to withhold consent to medical treatment. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 260-70 (1990). Treatment without informed consent was a battery at common law and remains actionable in most States today, with the inquiry in most cases focusing on whether the patient was adequately informed about the risks and benefits of a particular treatment.[17]

The second doctrine, even more strongly held, is that one who intentionally acts to cause or contribute to another's death is, with rare exceptions, guilty of criminal conduct.

> As this Court has observed:
>
> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280.

The potential for conflict between these two legal traditions arose with the advent of medical machines capable of performing the body's essential functions—breathing, eating, and drinking. While these machines were designed to allow life to be maintained while therapeutic benefits were obtained from other treatments, their use also results in individual situations where life can be mechanically preserved long after death would ordinarily come through the natural progression of the patient's disease or condition. The question then

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[17] The common law rule has been statutorily abrogated in Washington. Treatment without informed consent is actionable only if "a reasonably prudent patient under similar circumstances would not have consented to the treatment if informed of [appropriate] material fact[s]." Wash. Rev. Code § 7.70.050(1)(c).

presented is whether the physician's obligation to follow the patient's desires to withhold or withdraw treatment would result in the physician being legally responsible for causing or contributing to the patient's death once those desires are implemented.

That issue—once hotly debated—is now resolved. It is well settled, through a series of lower (mostly State) court decisions and State statutes, that a physician who complies with the patient's choice not to institute treatment, or who implements a patient-directed withdrawal of treatment previously implemented, violates no law.[18] This allows the disease process to follow a natural course to death, while at the same time accommodating the two legal traditions. Patient autonomy is respected while conduct intended to cause death independent of natural forces is prohibited.

Throughout our nation's history, these legal doctrines have been central to the development of substantive law in two areas for which the States have been primarily responsible—regulation of societal conduct through development of the criminal law and regulation of health care practice. Together, they have informed the line that, in the end-of-life context, delineates physician conduct which is permissible from that which is not.

The Ninth Circuit decision below conflated these well-established doctrines with a force that enlarges the first, undercuts the second, and limits a State's ability to accommodate the competing interests served by each. As a result, the clear line of demarcation between what a

[18] In the only case involving this issue to come before this Court, the Court, assuming but not deciding, that there is a constitutionally protected liberty interest in refusing life-saving treatment, upheld a state procedural limitation on the exercise of such refusal. *Cruzan*, 497 U.S. at 284.

physician may do and must not do at the patient's request has been abandoned in favor of one that is difficult to ascertain and inherently unstable.

In this case, the Court is asked to confirm the action of the court below by adopting as a constitutional imperative a public policy that allows physicians to prescribe medications intended not for therapeutic purposes, but to cause their patients to die.

It is difficult to overstate the importance of what the Court is asked to do or the complexity of the considerations which surround it. The issue of physician-assisted suicide has been discussed and debated throughout the nation in a variety of media—from television and radio talk shows to scholarly medical[19] and legal[20] journals to the daily newspapers.[21] Voters in Washington and California have

[19] See, for example, the written testimony submitted to the House of Representatives Judiciary Subcommittee on the Constitution by Kathleen M. Foley, M.D., the Chief of Pain Service at Memorial Sloan-Kettering Cancer Center, on April 29, 1996. Dr. Foley attached to her written testimony a reference list identifying more than 150 articles—most from medical journals—touching on the subject. A copy of Dr. Foley's statement and referenced list may be downloaded via the Subcommittee's home page on the internet (http:\\www.house.gov\judiciary\2167.htm).

[20] See, for example, 18 Seattle U. L. Rev. No. 3 (Spring 1995), 72 U. Det. Mercy L. Rev. No. 4 (Summer 1995), and 35 Duq. L. Rev. (Special Issue) (Fall 1996), each devoted to the issue.

[21] See, for example, Paul Wilkes, *The Case Against Doctor-Assisted Suicide, The Next Pro-Lifers*, N.Y. Times Magazine, July 21, 1996, at 22-27, 42, 45, 50-51; Carol J. Castaneda, *Agonizing over the right to die*, USA Today, June 7, 1996, at 4A; *Doctor-assisted suicide decision*, Seattle Post Intelligencer, March 9, 1996, at A10 (editorial agreeing with decision below); and *Court confuses liberty, death*, The Oregonian, March 8, 1996, at C8 (editorial criticizing decision below).

defeated, albeit by close votes, initiatives that would have authorized forms of physician-assisted suicide in their respective States. App. Pet. Cert. at A-49. Voters in Oregon, by an even closer vote, have adopted a statute allowing what this Court is asked to declare a constitutional right—physician prescription of life-ending medications for terminally ill patients—although implementation of the statute has been enjoined as a result of litigation that may find its way to this Court as early as this term. *See Lee v. State of Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal docketed*, No. 95-35854 (9th Cir. argued July 9, 1996).

In recent years, legislation authorizing physician-assisted suicide has been introduced in the legislatures of at least fifteen States. Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 18 (1996).

Commissions in two of those states—Michigan and New York—have studied the various ethical, medical, legal, social, philosophical, and psychological issues surrounding the physician-assisted suicide debate. Each produced a thoughtful and provocative report, with the differences between their approaches and results illustrative of the complexity of the issues.[22]

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[22] The Michigan Commission on Death and Dying, *Final Report* (1994); The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). The Michigan Commission produced three separate reports—one recommending a change in Michigan law to allow physician-assisted suicide, one recommending procedures should such a change be made, and one recommending no change. None of these recommendations was endorsed by a majority of the members of the Commission, although the recommendation for a change in the law received more votes than the others. The New York State Task Force Report compiled as thorough an analysis of the various social, medical, psychological, philosophical, and legal issues touching on the assisted suicide debate as can be found anywhere. The Task Force, representing a broad spectrum of divergent view points, unanimously recommended that New York's statutory prohibition against assisting a suicide be retained. New York State Task Force Report at 119-141.

As these reports—indeed the hundreds of articles and books written on the subject—illustrate, the debate over physician-assisted suicide implicates a wide range of interests and points of view, including at least the following:

- Those who, like the patients for whom the Respondents advocate, are mentally competent and terminally ill adults who want to end their lives with physician assistance;
- Those, equally competent and ill, who nonetheless want to remain alive, but fear that allowing assistance to some increases the risk that they themselves may die involuntarily;
- Those who are not mentally competent or terminally ill but who face a risk of being viewed as both and thus placed at increased risk of dying involuntarily;
- Those whose apparent voluntary desire to end their lives may, in reality, be the product of an unrecognized emotional or mental disorder;
- Those who believe that social policy should support life at all costs and in every setting, and those who do not;
- Those who believe that the desires of an individual, even one who may be operating under the effect of a mental disease or disorder, should prevail in all circumstances, and those who do not;

- Those who value self-determination but fear that shifting the line of permissible physician conduct into the realm of assisted suicide will place many vulnerable individuals at risk of an untimely and unwanted death.

This Court should resist the temptation to assert itself as the arbitrator of this complex and challenging issue, and leave the formulation of public policy to the State legislative arena where it has traditionally resided.

B. The Decision Below Is A Radical Departure From Our Nation's Legal Traditions And This Court's Fourteenth Amendment Jurisprudence

The decision below is replete with anecdotal recitations of the toll that terminal illness has inflicted on some individuals as they approach the end of life. *See, e.g.*, App. Pet. Cert. at A-11 to A-13, A-54 n.62, A-57, A-58, A-84 n.98, A-106 to A-108, A-109 n.135. These accounts cannot be read without evoking at least two strong emotional reactions—sympathy for those afflicted, and apprehensiveness that some day a similar fate may befall the reader or a loved one. The proposition advanced by Respondents and apparently subscribed to by the Ninth Circuit—that such suffering would be alleviated by finding a constitutional right to assisted suicide—is unquestionably inviting.

There are, of course, stories that make a different point:

- The story of a New York woman, a multiple sclerosis victim, who committed suicide with the encouragement of her husband. Excerpts from her husband's diary, which came to light after her death, suggested that his encouragement of her suicide was motivated, at least in part, by his own wish to be free of the burden of taking

care of his ailing wife. Rather than face a jury, the husband pled guilty to attempted manslaughter.[23]

- The story of a Seattle man who, though diagnosed with terminal pancreatic cancer, was able with modern pain management techniques to be active until shortly before his death. According to his wife, "[w]e went fly-fishing three weeks before he died . . . . It made all the difference in the world to be able to do things together—continue having fun while living with this knowledge that it's not going to be forever. I look back on those last six months as among the best we had."[24]

- The story of a Virginia woman who was born with cerebral palsy and, among other things, needed several surgeries to connect her malformed esophagus to her stomach. She survived one suicide attempt, and her doctor resisted her thinly-veiled requests that he assist her in another, instead persuading her to undergo yet another surgery. Two weeks after the surgery she was eating on her own, planning a new wardrobe, and contemplating a return to college.[25]

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[23] Herbert Hendin, *Dying of Resentment*, N.Y. Times, March 21, 1996, at A19.

[24] Cecelia Goodnow, *True reliever*, Seattle Post Intelligencer, July 25, 1996, at D1.

[25] Paul Wilkes, *The Case Against Doctor Assisted Suicide, The Next Pro-Lifers*, N.Y. Times Magazine, July 21, 1996, at 22-23.

But this Court's jurisprudence has not been and should not be determined on the basis of anecdotes, no matter what points they make or how compellingly they make them. This Court must focus on the needs of our society as a whole and its role in responding to those needs, and it must do so in a principled manner that builds upon, but does not distort, its prior jurisprudence. The Ninth Circuit decision departed from this Court's jurisprudence in several important respects.

1. The Ninth Circuit's Broad Characterization Of The Issue Ignored This Court's Restrained Analytical Approach To Substantive Due Process Cases

Respondents' claims are cast under the substantive component of the Due Process Clause, which has been recognized as protecting individual liberty against "certain government actions regardless of the fairness of the procedures used to implement them." *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (*citing Daniels v. Williams*, 474 U.S. 327, 331, 106 S. Ct. 662, 88 L. Ed. 2d 662 (1986)). The *Collins* Court observed:

> "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended. The doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field." *Id.*[26]

[26] *See also Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986):

> "Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. . . . There should be,therefore, great resistance to expand the substantive reach of [the Due Process Clause] particularly if it requires redefining the category of rights deemed to be fundamental."

This caution is reflected in the Court's analytical approach in due process cases. The analysis "must begin with a careful description of the asserted right.." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The degree of specificity with which the asserted right is described is important and may be determinative of the extent to which the claim of constitutional protection is recognized. *See* Laurence H. Tribe, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990).[27]

In deciding Respondents' claims that their terminally ill patients have a constitutionally protected liberty interest in physician-assisted suicide, the Ninth Circuit *en banc* panel cast its net broadly:[28]

> "[W]e first determine whether there is a liberty interest in choosing the time and manner of one's

[27] For example, in *Bowers*, which involved a challenge to a state statute outlawing sodomy, the majority characterized the issue as whether there exists "a fundamental right [for] homosexuals to engage in acts of consensual sodomy" (*Bowers*, 478 U.S. at 192), while the dissent characterized the issue as whether "individuals [have] the right to decide for themselves whether to engage in particular forms of private, consensual sexual activity" (*id.* at 199 (Blackmun, J., dissenting)).

[28] The Ninth Circuit noted, correctly, that "[u]nder the Court's traditional jurisprudence, those classified as fundamental rights cannot be limited except to further a compelling and narrowly tailored state interest," but that individual liberty interests such as are asserted here are subject to lesser protection. App. Pet. Cert. at A-33. *See also Cruzan*, 497 U.S. at 279 n.7.

death . . . in common parlance . . . Is there a right to die?" App. Pet. Cert. at A-21.

Not only is the breadth of the Ninth Circuit's characterization of the asserted liberty interest inconsistent with this Court's careful analytic approach, it is problematic in other respects as well. If there is indeed a constitutionally protected liberty interest in "determining the time and manner of one's death," not only laws banning assisted suicide are suspect. Also at risk are such statutes as, for example, those prohibiting the sale of transplantable human body parts[29] and denying access to ineffective medications[30], as well as the well-established rule that consent of the victim is not a defense to a murder charge.[31]

Moreover, by phrasing the question—and its answer—broadly, the Ninth Circuit disregarded the *Cruzan* Court's "judicious counsel . . . that in deciding 'a question of such magnitude and importance . . . it is the better part of wisdom not to attempt, by any general statement, to cover every possible phrase of the subject.'" *Cruzan*, 497 U.S. at 277-78 (citation omitted) (second ellipsis in original).

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[29] *See, e.g.*, Wash. Rev. Code § 68.50.610; 42 U.S.C.S. § 274e; *see also* Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Reasons Are Not Convincing*, 12 Issues in L. & Med. 113, 114 (1996).

[30] In *United States v. Rutherford*, 442 U.S. 544 (1979), this Court upheld the statutory authority of the Food and Drug Administration to prohibit the sale or distribution of a drug (laetrile) that had not been shown to be effective, rejecting the suggestion that an exception be made for terminally ill cancer patients. On remand, the Tenth Circuit upheld the constitutionality of the prohibition. *Rutherford*, 616 F.2d 455 (10th Cir. 1980), *cert denied* 449 U.S. 937 (1980).

[31] *See, e.g., Martin v. Commonwealth*, 184 Va. 1009, 1018-19, 37 S.E.2d 43 (1946).

The *Cruzan* Court assumed, but did not decide, that "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving treatment and nutrition" (*id.* at 279) and upheld a State procedural limitation on the exercise of the assumed right (*id.* at 284).

This Court should follow its prior teachings, and its *Cruzan* example, and focus its analysis on the narrow issue before it in this case—whether there is a liberty interest protected by the Fourteenth Amendment in committing suicide that includes assistance in doing so.

2. The Asserted Liberty Interest In Suicide Or Assisted Suicide Is Neither Deeply Rooted In Our Nation's History And Traditions Nor Implicit In The Concept Of Ordered Liberty

The Court's principal "guideposts for responsible decision making" (*Collins*, 503 U.S. at 125) in determining the existence of a constitutionally protected liberty interest have been our nation's history and legal traditions. The Court has said that the category of "rights qualifying for heightened judicial protection . . . includes those fundamental liberties that are 'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if they were sacrificed.'" *Bowers*, 478 U.S. at 191-92 (*quoting Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937)). An alternative statement also recognized by the *Bowers* Court was Justice Powell's characterization of constitutionally protected liberties as those that are "deeply rooted in this nation's history and tradition." *Id.* at 192 (*quoting Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.)).

While conceding the correctness of the *Bowers* Court formulation[32], the Ninth Circuit downplayed the significance of the historical view of our Nation and its legal traditions.

> "Were history our sole guide, the Virginia anti-miscegenation statute that the Court unanimously overturned in *Loving v. Virginia*, 388 U.S. 1 (1967), . . . would still be in force." App. Pet. Cert. at A-36.

Although the result in *Loving* reflected current societal attitudes about relations among people from diverse ethnic and racial backgrounds, the Court based its due process holding squarely on its recognition that "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness." *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

There is no parallel element of our historical concept of liberty upon which to base the interest in physician-assisted suicide that is asserted in this case.

The limited historical analysis that was conducted by the Ninth Circuit combined a selective reading of the most comprehensive scholarly treatment of legal issues

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[32] The Ninth Circuit's limited *en banc* panel dismissed the holding of *Bowers* on the basis of a subsequent statement by Justice Powell, who voted with the 5-4 majority, that he had "probably made a mistake." App. Pet. Cert. at A-31 n.16. As noted above, page 19 note 27, one difference between the *Bowers* majority and the dissent was their characterization of the issue there involved. However, both the majority and the dissent looked to our nation's history and traditions to determine whether constitutional protection was warranted, and the court below acknowledged that the *Bowers* Court's formulation of the test for the existence of a protected liberty interest "is not controversial." *Id.* at A-31 n.16.

surrounding suicide and assisted suicide[33] with occasional examples of notorious suicides in mythology and literature. *See* App. Pet. Cert. at A-30 to A-47.

This selective and incomplete analysis glossed over the fact that throughout our legal traditions—from the English common law to colonial times to the present—suicide and attempted suicide have been disfavored and have resulted in adverse legal consequences. *See generally* Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1 (1985). For several centuries, the act of attempting suicide was a crime, both in the English common law and in many State statutes. *Id.* at 56-100.

Over time, attitudes toward suicide softened, not because it was considered acceptable, but because of a growing recognition that those who attempted suicide were led to do so because of a mental disease or an emotional disorder, rather than as a noble act of self-determination. Thus, while it is true that "[t]oday, no state has a statute prohibiting suicide or attempted suicide" (App. Pet. Cert. at A-47), virtually every State recognizes a suicide attempt as sufficiently indicative of a mental disorder to justify involuntary commitment for mental health evaluation and treatment.[34]

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[33] Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1 (1985). A thorough explication of the extent to which the Ninth Circuit misread or mischaracterized the historical evidence reviewed in this article may be found in Thomas J. Marzen, et al., *"Suicide: A Constitutional Right"—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261, 262-68 (1996).

[34] See, for example, Wash. Rev. Code §§ 71.05.020(3) and 71.05.240. The New York State Task Force noted that "[s]tudies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." New York State Task Force Report at 11.

Other than noting, correctly, that "[a] majority of states . . . still have laws on the books against assisting suicide" (App. Pet. Cert. at A-47), the Ninth Circuit limited *en banc* panel made no attempt to determine if access to assistance in committing suicide was "implicit in the concept of ordered liberty" or "deeply rooted in this nation's history and tradition."

The reason for this lack of inquiry is, of course, that any such attempt would fail. Though the historical record is incomplete, it appears that most colonial governments viewed assisting a suicide as a common law crime (Marzen, at 70-74, *supra* p. 23), and statutes like the Washington statute at issue here remain on the books in most states. *See supra* p. 6 n.13; *see also People v. Kevorkian*, 447 Mich. 436, 495, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1785 (1995) (holding *inter alia* that assisted suicide remains a common law offense in Michigan today).

The possibility that one who assists a would-be suicide is acting other than altruistically no doubt accounts for the fact that most States continue to view assisting a suicide as a crime.

> "[I]n principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even . . . with the consent, or at the request, of the suicide victim." American Law Institute, *Model Penal Code and Commentaries, Part I*, § 210.5 at 100.

See also supra p. 5 (comments of the drafters of the current version of the Washington statute).

Even if the Ninth Circuit was correct in concluding that suicide has not been universally condemned, the mere absence of universal condemnation does not establish a

right. Neither Respondents nor the Court below have identified any positive source of the asserted right that is "implicit in the concept of liberty."

As the Second Circuit concluded:

> "Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history . . . . Indeed the very opposite is true." *Quill v. Vacco*, 80 F.3d 716, 724 (2nd Cir. 1996) (*cert. granted sub nom. Vacco v. Quill*, Case No. 95-1858, to be argued in tandem with the instant case).

But arguing that the opposite is *not* true, which is all the Ninth Circuit opinion does, does not transform suicide into a right deeply rooted in the nation's history and traditions.

3. The Decision Below Departs From This Court's Substantive Due Process Jurisprudence By Creating A Protected Interest That Is Not Rooted In Our Historical Concepts Of Liberty And Is Different In Character And Quality From Other Protected Liberty Interests Recognized By This Court

This Court's substantive due process jurisprudence has recognized protected liberty interests in marriage,[35] procreation,[36] and the decision to bear a child.[37] In

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[35] *Loving v. Virginia*, 388 U.S. 1 (1961); *Turner v. Safley*, 482 U.S. 78 (1987).

[36] *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Carey v. Population Services International*, 431 U.S. 678 (1977).

[37] *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

according constitutional protection to these activities, the Court considered the nature of the activity, the importance that it plays in the individual's enjoyment of the full range of liberty, and the State interests arguably advanced by the particular governmental restriction involved. The alleged liberty interest in physician-assisted suicide is different in a number of respects than the interests to which constitutional protection has previously been granted.

Each of the Court's earlier cases involved activities that allow the individual a broader participation in life and society, e.g., to enjoy the benefits of marriage to whomever one pleases, regardless of race, or to pursue or avoid the combination of blessings and burdens that parenthood brings.

A decision to terminate one's life, on the other hand, has exactly the opposite effect—once executed, life itself, along with its burdens and benefits, is gone.

The Court has also recognized liberty interests in avoiding unwanted medical treatment[38] and *assumed* that such an interest was implicated even where the treatment consisted of artificial nutrition and hydration necessary to preserve the life of the patient.[39]

Such interests, perhaps more closely analogous to the interest advanced here, are rooted in the individual's freedom from "[t]he State's imposition of medical treatment on an unwilling competent adult [which] necessarily involves some form of restraint and intrusion." *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring).

Assisted suicide invites, rather than avoids, bodily intrusion. The informed consent doctrine on which the

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[38] *Washington v. Harper*, 494 U.S. 210 (1990).

[39] *Cruzan*, 497 U.S. at 267.

Harper/Cruzan line of cases is anchored simply does not provide doctrinal support for the proposition that there is a liberty interest in physician-assisted suicide.

Both the District Court and the Ninth Circuit limited *en banc* panel analogized the interest here to a woman's decision to terminate a pregnancy.

> "In examining whether a liberty exists in determining the time and manner of one's death, we begin with the compelling similarities between right-to-die cases and abortion cases." App. Pet. Cert. at A-25.

While there may be similarities between the two issues, the similarities are superficial at best, and there are significant differences as well. The Ninth Circuit's disregard of those differences is another example of its departure from this Court's cautious analytical approach to substantive due process claims.

First, and foremost, from a constitutional point of view, the abortion decision does not implicate the life of a person.

> "The Court in *Roe* carefully considered, and rejected, the . . . argument 'that the fetus is a 'person' within the language and meaning of the Fourteenth Amendment' . . . [T]he Court concluded that that word 'has application only postnatally.'" *Planned Parenthood v. Casey*, 505 U.S. 833, 913 (Stevens, J., concurring in part and dissenting in part).

Secondly, from a practical point of view, any attempt to regulate the abortion decision perforce impacts women more profoundly than men, seriously implicating equal

protection considerations that are absent in respect to assisted suicide.[40]

Finally, what is at stake in the abortion context is the decision whether to have a child, something over which humans can exercise a great deal of personal autonomy. This case involves death, which ultimately humans have little, if any, ability to control. Death is in fact the antithesis of liberty—neither can coexist with the other. Finding a liberty interest in the former context accords with reality; to do so in the latter does not.

The Ninth Circuit *en banc* panel attempted to anchor its decision on two recent cases from this Court: *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). In reality, it distorted the holdings of both.

(a) *Cruzan*

In *Cruzan*, this Court considered whether Missouri could require clear, cogent, and convincing evidence of a patient's desire before authorizing termination of artificial life support, including nutrition and hydration.

Recognizing that the common law doctrine of informed consent included a co-terminus right to refuse consent, the Court reviewed a series of cases involving intrusive actions, such as immunization and forced medical treatment, and concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, 497 U.S.

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[40] "[S]ome commentators and judges . . . have suggested that the constitutional theory of sex equality . . . better supports the constitutional protection afforded the abortion decision." Marc Spindelman, *Are The Similarities Between a Woman's Right to Choose an Abortion and the Alleged Right to Assisted Suicide Really Compelling?* 29 U. Mich. J.L. Reform 775, 824 n.186 (1996).

at 278. However, the Court stopped short of holding that this principle extended to "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water." *Id.* at 279. Rather, the Court stated that "for purposes of this case, [it would] assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* That, of course, did not end the inquiry.

> "Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation." *Id.* at 280.

The State interests recognized in *Cruzan* included "the protection and preservation of human life" as reflected in the universally held view that homicide is a crime and that most states "have laws imposing criminal penalties on one who assists another to commit suicide." *Id.*

The *Cruzan* Court noted that this State interest could justify forced nutrition, at least under some circumstances:

> "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Id.*

The *Cruzan* Court also recognized that the Missouri rule also served "more particular interests"—preventing abuse or undue influence. *Id.* at 281. And it rejected the notion that these State interests varied from one person to another:

> "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life

to be weighed against the constitutionally protected interests of the individual." *Id.* at 282.

Unlike *Cruzan*, this case is not about governmentally forced medical or nutritional procedures. Individuals who require artificial life-support are by definition excluded from the category of individuals on whose behalf Respondents advocate.

To the contrary, Respondents seek to require the government to permit them to take affirmative steps to help their patients die, not as a result of the natural course that is followed when artificial life support is foregone or withdrawn, but as a direct and intended result of an artificial death-inducing intervention.

Such a holding is beyond the scope of *Cruzan* and not supported by the common law doctrine which formed the basis for the *Cruzan* opinion.

Rather than supporting the decision below, the *Cruzan* opinion confirms that the important State interests present in this case outweigh any asserted liberty interest in assisted suicide.

(b) *Casey*

The Ninth Circuit also attempted to anchor its decision on this Court's holding in *Casey*. App. Pet. Cert. at A-56 to A-58. The *en banc* panel attempted to transform a three-sentence passage into a new formulation of the test for the existence of a protected liberty interest. In so doing, it ignored the context in which *Casey* was decided, its focus on the specific issue of "a woman's right to terminate her pregnancy" (*Casey*, 505 U.S. at 844), and the role that *stare decisis* played in the *Casey* decision.

The primary issue in *Casey* was whether the Court should retreat from its "holding that the Constitution protects a woman's right to terminate her pregnancy in its early stages, *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705,

35 L. Ed. 2d 147 (1973)." *Casey*, 505 U.S. at 844. The *Casey* Court declined to do so:

> "After considering the fundamental constitutional questions resolved by *Roe*, principles of institutional integrity, and the rule of *stare decisis*, we are led to conclude this: the essential holding of *Roe v. Wade* should be retained and once again reaffirmed." *Casey*, 505 U.S. 845-46.

Discussing *Roe* and its antecedents, the *Casey* Court noted that the Due Process Clause "affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. . . . [M]atters . . . involving the most intimate and personal choices a person may make in a lifetime." *Id.* at 851.

From the context, it is clear that this language described specific interests accorded constitutional protection in prior cases. There is nothing in content or context to suggest that the *Casey* Court intended this language as a reformulation of the test for determining the existence of a liberty interest.

This is even more clear from Part III of the Court's opinion, explaining the important influence of the doctrine of *stare decisis* in the *Casey* conclusion:

> "Where, in the performance of its judicial duties, the Court decides a case in such a way as to resolve the sort of intensely divisive controversy reflected in *Roe* and those rare comparable cases, its decision has a dimension that the resolution of the normal case does not carry. It is the dimension present whenever the Court's interpretation of the Constitution calls the contending sides of a national controversy to end their national division by accepting a common mandate rooted in the Constitution." *Id.* at 866-67.

In such situations, the *Casey* Court noted:

> "[The Court's] decision[s] require[] an equally rare precedential force . . . [lest] a later decision overruling the first [be seen as] a surrender to political pressure, and an unjustified repudiation of the principle on which the Court staked its authority in the first instance. . . . [T]o overrule under fire in the absence of the most compelling reason to reexamine a watershed decision would subvert the Court's legitimacy beyond any serious question." *Id.* at 867.[41]

In summary, the *Casey* Court reaffirmed the essential holding of *Roe v. Wade* because it was consistent with, albeit an extension of, other substantive due process cases *and* because the Court's institutional integrity required a forceful application of the principles of *stare decisis* to such a "watershed decision" as *Roe*.

That *Casey*'s reaffirmation of *Roe* does not represent an expansion of substantive due process beyond the reproductive rights arena is clear from the *Casey* Court's observation that "*Roe*'s scope is confined by the fact of its concern with postconception potential life, a concern otherwise likely to be implicated only by some forms of contraception protected [by earlier] cases." *Casey*, 505 U.S. at 859.

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[41] These considerations reinforce the need for the Court to be particularly cautious before attempting to resolve the policy debate over whether and under what circumstances physician-assisted suicide should be allowed. This case presents another "watershed" issue involving an "intensely divisive controversy." The Court should refrain from finding a constitutionally mandated answer to this "national controversy," because it cannot do so with sufficient clarity that its answer will withstand inevitable efforts to overturn it and thwart its implementation.

In short, the Ninth Circuit *en banc* panel's reliance on *Casey* was misplaced.

4. The Balancing Test Used By The Ninth Circuit Undervalued Legitimate State Interests That Are Furthered By The Statute At Issue

The Ninth Circuit, having over-stated the nature of the liberty interest involved and under-stated the extent to which recognition of such an interest would depart from our nation's history and traditions, also departed from this Court's substantive due process jurisprudence in the way in which it evaluated legitimate State interests furthered by the Washington statute.

Consider, for example, the *en banc* panel's treatment of this Court's teaching in *Cruzan*, that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan*, 497 U.S. at 282. While noting this passage, the Ninth Circuit concluded that the "*strength* [of the State's interest] is dependent on relevant circumstances, including the medical condition" of the patient. App. Pet. Cert. at A-65 (emphasis in original). The Ninth Circuit does not explain how a State can, under this construct, assess the strength of its interest without making "judgments about the 'quality' of life that a particular individual may enjoy," precisely what the *Cruzan* Court said a State is not required to do.[42]

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[42] The *Cruzan* Court was aware of Ms. Cruzan's tragic circumstances. *Cruzan*, 497 U.S. 266-67 n.1. If the Ninth Circuit's "sliding scale" approach were correct, it would be difficult to imagine a case where the State's interest would have been weaker. Yet, this Court in *Cruzan* concluded that the general State interests in preserving life and particularized interests in preventing abuse or undue influence

Similarly, the Ninth Circuit considered, and dismissed, other State interests, performing its own evaluation of the "strength" of those interests in the circumstances of the mentally competent, terminally ill patient who wishes to commit suicide. By focusing its analysis on the strength, rather than the nature, of the implicated State interests, the Court below was able to substitute its judgment for that of the Washington Legislature as to which of several competing interests should be given preference.

For example, in recognizing the State's legitimate interest in "preventing deaths that occur as a result of errors in medical or legal judgment," the Court

> "acknowledge[d] that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is sometimes impossible to say for certain whether a borderline individual is or is not mentally competent." App. Pet. Cert. at A-83.[43]

At the same time, the Ninth Circuit ignored the inevitability of "situations in which family members will not act to protect a patient." *Cruzan*, 497 U.S. at 281.

These possibilities raise concerns that any attempt to limit assisted suicide to mentally competent, terminally ill adults will fail, with the result that some individuals will be

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outweighed the individual liberty interest assumed to exist in that case.

[43] This Court has recognized as well "that with diseases such as cancer it is often impossible to identify a patient as terminally ill except in retrospect." *United States v. Rutherford*, 442 U.S. 544, 556 (1979). The Ninth Circuit's failure to articulate a clear definition of when a patient is "terminal" or the standard of "mental competence" to be used in determining eligibility for suicide assistance makes such judgments that much more complicated and error prone.

helped to die even if they do not meet either or both criteria.

Such concerns are, in the Ninth Circuit's view, minimal, because "should an error actually occur it is likely to benefit the individual by permitting [the patient] . . . to end his life peacefully and with dignity." App. Pet. Cert. at A-83. In other words, to the Ninth Circuit limited *en banc* panel, a peaceful death, even erroneously administered, is preferable to an erroneous extension of life.

However, is it not an equally legitimate view that the risk of "wrongful" extension of life is preferable to premature unwanted death? As this Court noted in *Cruzan*,

> "[a]n erroneous decision not to terminate [life support maintains] the status quo; the possibility of subsequent developments . . . at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction." *Cruzan*, 497 U.S. at 283.

The same may be said for assisted suicide.

The Court below also attempted to justify its evaluation of various state interests by comparing Washington's approach to the related—yet different—issue of patient refusal of treatment. Thus, while the State may "assert an unqualified interest in the preservation of human life" (App. Pet. Cert. at A-65 (*citing Cruzan*, 497 U.S. at 282)), Washington's interest in preserving life, according to the Ninth Circuit, is weakened because of the Legislature's adoption of the Natural Death Act, Wash. Rev. Code Ch. 70.122 (App. at 1a-11a), setting forth procedures by which an individual may indicate his or her desire to forego artificial life support.

According to the Court below, this statute reflects "Washington's *recognition* that the state's interest in

preserving life is not always of the same force and that in some cases at least other considerations may outweigh the state's." App. Pet. Cert. at A-68 (emphasis added). However, the statute could just as easily be viewed as a legislative *choice* among competing interests and values in a specific context, a choice that is admittedly different in kind and degree from that reflected in the statute and context at issue here. In any event, the Ninth Circuit did not explain how creation of a statutory right based on common law principles mandated recognition of a constitutionally protected liberty interest inconsistent with the common law.

Certainly, the Washington Legislature did not believe that by enacting the Natural Death Act it was abandoning opposition to assisted suicide:

> "Nothing in [the Natural Death Act] shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying." Wash. Rev. Code § 70.122.100.

Similarly, the Court below independently assessed the "strength" of the State's interest in preventing suicides:

> "[W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . In sum, we find the state's interests in preventing suicide do not make its interests substantially stronger here than in cases involving other forms of death-hastening medical intervention. To the extent that a difference exists, we conclude that it is one of degree and not of kind." App. Pet. Cert. at A-82.

While the Ninth Circuit may see no differences between withdrawing life support and assisted suicide, most other courts have.[44]

Consider the following examples:

The Washington State Supreme Court:

- "We emphasize that we are not endorsing suicide or euthanasia." *In re Grant*, 109 Wash. 2d 545, 563, 747 P.2d 445 (1987).

The New Jersey Supreme Court:

- "We would see, however, a real distinction between the self-infliction of deadly harm [suicide] and a self-determination against artificial life support . . . ." *Matter of Quinlan*, 70 N.J. 10, 43, 355 A.2d 647 (1976).

The Arizona Supreme Court:

- "Asserting the right to refuse medical treatment is not tantamount to committing suicide." *Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674 (1987).

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[44] *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court of Los Angeles (Glendale Adventist Med. Ctr.)*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220 (1984); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720 (Conn. Super. Ct. 1984); *Staz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978); *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651, 652 (1989); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626, 638 (1986); *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404, 411 (1987); *Matter of Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 273, 420 N.E.2d 64, 71 n.6 (1981); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc. 1, 426 N.E.2d 809, 815 (1980); *In re Grant*, 109 Wash. 2d 545, 563, 747 P.2d 445 (1987).

The Maine Supreme Court :

- "[A patient's] decision not to receive [medical procedures], far from constituting suicide, is a choice to allow to take its course the natural dying process set in motion by his physiological inability to chew or swallow." *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (citations omitted).

As this Court has noted:

"It is conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other." *Casey*, 505 U.S. at 851.

It is manifest that the Ninth Circuit's evaluation of the State interests involved differed from that of Washington's Legislature in adopting Wash. Rev. Code § 9A.36.060, and from that of Washington's voters in rejecting Initiative 119. What is not manifest is why one assessment is correct and the other is not.

5. This Court Should Reject The Ninth Circuit's "As Applied" Approach To Substantive Due Process Claims And Uphold Washington's Statute That Furthers Legitimate State Interests

Respondents alleged that the statute is unconstitutional on its face. J.A. at 7. The District Court agreed. App. Pet. Cert. at E-28 to E-29, I-1 to I-3. In their Ninth Circuit Reply Brief, Respondents recast their challenge to the statute:

> "Appellees have challenged RCW 9A.36.060 both on its face and as applied to them individually." Br. Appellees at 29.

The limited *en banc* panel, finding it "extremely unlikely that the district judge intended to strike down the

entire statute" (App. Pet. Cert. at A-18 n.18), transformed the District Court decision into a different kind of ruling:

> "[I]t appears that [the District Court] declared the statute invalid only insofar as it applies to the prescription of medication to terminally ill competent adults . . . or, to use the district court's precise terminology, only insofar as it applies to 'physician-assisted suicide[.]'" App. Pet. Cert. at A-18.

The limited *en banc* panel then held that "the 'or aids' provision of Washington statute RCW 9A.36.060, as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment." App. Pet. Cert. at A-19 to A-20.

By characterizing its ruling as an "as applied" holding, the Ninth Circuit disguised the extent to which it was merely substituting its judgment for that of Washington's Legislature and voters about the appropriate scope of this statute.

The core of the Ninth Circuit limited *en banc* panel's ruling, and of Respondents' argument in this case, is that the statute operates imperfectly, that "as applied" to the hypothetical mentally competent, terminally ill person who decides, free of undue influence or coercion, to commit suicide, the statute serves no legitimate State interest and is therefore arbitrary. However, as this Court has observed in *Cruzan*:

> "[T]he Constitution does not require general rules to work faultlessly; no general rule can." *Cruzan*, 497 U.S. at 284.

And in *Romer v. Evans*, 116 S. Ct. 1620 (1996):

> "Even laws enacted for broad and ambitious purposes often can be explained by reference to legitimate public policies which justify the incidental disadvantages they impose on certain persons." *Romer*, 116 S. Ct. at 1628.

Respondents' argument overlooks the differences between the hypothetical group for whom they advocate and the real world, where the *potential* for abuse and undue influence is present in *every* situation.

As the New York State Task Force concluded:

> "For purposes of public debate, one can posit 'ideal' cases in which all the recommended safeguards would be satisfied: patients would be screened for depression and offered treatment, effective pain medication would be available, and all patients would have a supportive, committed family and doctor. Yet the reality of existing medical practice in doctors' offices and hospitals across the state generally cannot match these expectations, however any guidelines or safeguards might be framed. These realities render legislation to legalize assisted suicide and euthanasia vulnerable to error and abuse for all members of society, not only for those who are disadvantaged. The argument for mercy or compassion then is complex. Constructing an ideal or 'good' case is not sufficient for public policy, if it bears little relation to prevalent medical practice." *See* New York State Task Force Report, at 120.

An "as applied" challenge provides the means for one who is impacted by a law to ask the court to balance the individual liberty interests against the interests of society. It is not an invitation to the court to base its judgment on the law only on how it applies to that individual.

In making public policy, a State legislature—which in Washington and many other States includes the people through the initiative process—must consider a wide variety of interests and strike a balance that, in their collective judgment, best serves the needs of all of the State's citizens.

This Court should reject the Ninth Circuit's use of an "as applied" substantive test to second guess the legislative judgment reflected in the statute at issue here.

C. Washington Law Does Not Violate The Equal Protection Clause

Respondents also claim that Washington's ban on assisted suicide violates the equal protection clause of the Fourteenth Amendment. J.A. at 7.[45] This claim is based on Washington's Natural Death Act[46] which permits an individual to "execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition." Wash. Rev. Code § 70.122.030(1) (App. at 4a). The thrust of their argument is that individuals who seek physician-assisted suicide and those who seek withdrawal of life-sustaining treatment are similarly situated and that

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[45] This issue of whether States whose statutes allow refusal or withdrawal of life support while at the same time prohibiting assisted suicide violates the Equal Protection Clause is more squarely presented in New York's appeal of the Second Circuit's decision in *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted sub nom. Vacco v. Quill*, No. 95-1858, to be argued in tandem with the instant case.

[46] Wash. Rev. Code §§ 70.122.010-.910 (App. at 1a-11a).

there is no rational basis for banning one and permitting the other.[47]

The Equal Protection Clause is "essentially a direction that all persons similarly situated should be treated alike." *Cleburne v. Cleburne Living Center*, 473 U.S. 432, 439 (1985). "The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest." *Id.* at 440.

Respondents have not met the threshold test for equal protection because they have not shown that the two groups are similarly situated. There is a significant difference between terminally ill patients who can breathe, eat, and drink on their own and terminally ill patients who are being kept alive only by artificial means. The patient kept alive by artificial means suffers restraint and bodily intrusion from the unwanted treatment. As Justice O'Connor observed in *Cruzan*:

> "The States' imposition of medical treatment on an unwilling competent adult necessarily involves some form of restraint and intrusion. A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion." *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring).

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[47] The District Court ruled that this constituted an equal protection violation. App. Pet. Cert. at E-25 to E-28. This ruling was reversed by the three judge panel of the Ninth Circuit. App. Pet. Cert. at D-18 to D-19. The *en banc* panel of the Ninth Circuit did not reach this question (App. Pet. Cert. at A-115), although its due process analysis was strongly flavored with equal protection principles. *See* pp. 35-38 *supra*; Pet. at 22-28.

A terminally ill patient who is not receiving unwanted treatment is not subject to this restraint and bodily intrusion. The New York State Task Force Report also recognized this distinction:

> "If a patient is denied medically assisted suicide or euthanasia, he or she is likely to die more slowly of natural causes. When a competent patient is denied the option of refusing treatment, he or she will not only have life prolonged, *but must be physically forced to undergo unwanted treatment*. Whether the treatments are highly invasive such as chemotherapy or a respirator, or are generally regarded as less intrusive such as antibiotics, *the patient's body is physically invaded without consent. Under the common law, this is called battery*." New York State Task Force Report at 146 (emphasis added).

In sum, the two groups are not similarly situated because, while both may be said to be terminally ill, only one is suffering from the restraint and intrusion of unwanted medical treatment.

The significant practical distinction between these two groups is plainly rational. It is based on the common law doctrine of informed consent, which includes the right to refuse medical treatment. In *Cruzan*, this Court reviewed a number of State decisions on this point and concluded that:

> "As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." *Cruzan*, 497 U.S. at 277.

This also is the case in Washington. The underpinnings of the Natural Death Act include the recognition that a patient may refuse unwanted medical treatment. *In re Colyer*, 99 Wash. 2d 114, 121, 660 P.2d 738 (1983)

("The common law right to be free from bodily invasion is an alternative basis for the right to refuse life sustaining treatment. Historically, an operation without authorization constituted an assault and battery, as well as malpractice." (citation omitted)).

The distinction between the two groups is also rational because it is based on the strongly held doctrine that one who intentionally acts to cause or contribute to another's death is, with rare exceptions, guilty of criminal conduct. As this Court stated in *Cruzan*:

> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280.

As noted above on pages 35 and 36, Washington did not abandon this doctrine when it adopted the Natural Death Act. Wash. Rev. Code § 70.122.100 provides:

> "Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying."

In short, the Equal Protection Clause does not provide an alternative basis for upholding the decision below.

D. There Is No Principled Basis On Which The Asserted Right To Assisted Suicide Can Be Limited To Physician Prescription Of Medication For Mentally Competent, Terminally Ill Patients To Administer To Themselves

It may be tempting to believe that the impact of the decision below will be mitigated because, by its terms, it

applies only to "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors." App. Pet. Cert. at A-116.[48] If, however, this Court recognizes even a limited constitutional right to physician-assisted suicide, any attempt to confine it to such circumstances is likely to fail.

The Court has previously noted that its "power lies . . . in its legitimacy . . . [which] depends on making legally principled decisions under circumstances in which their principled character is sufficiently plausible to be accepted by the Nation." *Casey*, 505 U.S. at 865-66. In this regard, the Court differs from a legislative body which may, "[c]onsistent with other constitutional norms, . . . draw lines which appear arbitrary without the necessity of offering a justification." *Id.* at 870.

There is no principled basis on which the decision of the Ninth Circuit *en banc* panel can be limited to the prescription of medication for terminally ill patients to administer to themselves. One commentator, who has written widely on the subject, illustrates the problem of trying to limit the newly established right to the terminally ill:

> "If the merciful termination of suffering (or termination of an unendurable existence) is the basis for [the right to assisted suicide], why limit it to those who are terminally ill? . . . [U]nder a variety of circumstances life may be unendurable to a reasonable person, even though he does not face the prospect of immediate and painful death. . . . [I]s it [not] arbitrary to exclude the quadriplegic? The victim of a paralytic stroke? The mangled survivor of a road accident? A person afflicted with severe arthritis? . . . If a competent person comes to the unhappy

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[48] As noted in the Petition at pages 10-11, the substance of the decision below in fact telescopes a much broader impact.

> conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not 'qualify' under somebody else's standards?" Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, Hastings Ctr. Report 32, 36-37 (May-June 1993) (footnotes omitted) (quotation marks omitted).

Similarly, the newly created "right" to assisted suicide cannot be limited on any principled basis to those who are mentally competent. The Ninth Circuit limited *en banc* panel acknowledged as much:

> "Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." App. Pet. Cert. at A-101 n.120.

The court below also acknowledged that its decision to allow physician-assisted suicide, which it defined as "the prescribing of medication by a physician for the purpose of enabling a patient to end his life" (*Id.* at A-30), was not the final word on whether other forms of life-ending assistance must also be allowed:

> "We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician [i.e., active euthanasia]. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only

> way the patient may be able to receive them." *Id.* at A-100.[49]

Finally, the Ninth Circuit declined to limit its formulation of the newly created right to assistance by physicians, but also included friends, family members, and other health care workers who may facilitate the process within the scope of its ruling. *Id.* at A-116 n.140.

State legislatures, if left unhampered by a constitutional imperative of the sort contained in the decision below, have a broad range of discretion within which to operate on such a complex and controversial subject as physician-assisted suicide. Absent a principled basis upon which to affirm the decision below, this Court should reverse the Ninth Circuit and confirm the States' discretion to balance competing interests in a way that meets the needs of their respective populations.

E. Our Federal System Works Best When Important Questions Of Public Policy Are Resolved Through The State Legislative Process

The Ninth Circuit rejected the argument that the States are capable of forming their own judgments as to whether a policy allowing physician-assisted suicide would meet the needs of their respective populations:

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[49] *See also* App. Pet. Cert. at A-30 n.15 ("The issue of the constitutionality of prohibiting physicians from administering life-ending drugs to terminally ill persons [i.e., active euthanasia] is not before us."). Again, Professor Kamisar's comments are illuminating:

> "If the right to control the time and manner of one's death . . . is well-founded, how can it be denied to someone simply because she is unable to perform the final act herself? Although there is a 'mechanical' distinction between assisted suicide and euthanasia, is it not a distinction without a difference?" Kamisar, at 35, *supra* p. 46.

> "[A]llowing each state to decide whether to *prohibit* [assisted suicide] results [in] a patchwork-quilt pattern of prohibitory legislation." App. Pet. Cert. at A-105 n.124 (emphasis in original).[50]

The same could be said, of course, for a wide variety of contexts in which the States' approaches differ, from real property to contracts to tort liability to criminal law. One could construct an argument that a national rule in any of these areas would have benefits. This was not, however, an argument that the founders of our federal system found to be persuasive.

Nor should this Court. There is great benefit to be gained by allowing each State to grapple on its own with complex issues of public policy such as assisted suicide. Each State can benefit from sister States' experiences, avoiding those approaches that have proven problematic and adapting those that are successful to the needs of their local populations.

As Justice Brandeis pointed out:

> "It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1931) (Brandeis, J., dissenting).

Just as this Court "has the power to prevent an experiment [by striking] down the statute which embodies it" (*id.*), a pre-emptory decision by this Court on the issue

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[50] Of course, there is now no "patchwork" quilt since most States prohibit assisted suicide in all cases, and implementation of the one State statute permitting a limited form of physician-assisted suicide has been enjoined by the federal courts. *See supra* p. 6 n.13; p. 14.

of assisted suicide would freeze the process of experimentation that it presents and forestall the opportunity to learn.

State courts and legislatures are quite capable of resolving these issues *and* protecting individual interests without significant federal judicial assistance. As Justice Holmes observed:

> "[I]t must be remembered that legislatures are ultimate guardians of the liberties and welfare of the people in quite as great a degree as the courts." *Missouri, K.T.R. Co. v. May*, 194 U.S. 267, 270 (1904).

VII. CONCLUSION

For the reasons outlined above, the decision of the limited *en banc* panel of the United States Court of Appeals for the Ninth Circuit should be reversed and this matter remanded to the District Court with directions to enter summary judgment for the Petitioners.

Respectfully submitted this 8th day of November, 1996.

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APPENDIX

APPENDIX A

Chapter 70.122 RCW

NATURAL DEATH ACT

RCW 70.122.010 Legislative findings.

The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care, including the decision to have life-sustaining treatment withheld or withdrawn in instances of a terminal condition or permanent unconscious condition.

The legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The legislature further finds that, in the interest of protecting individual autonomy, such prolongation of the process of dying for persons with a terminal condition or permanent unconscious condition may cause loss of patient dignity, and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient. The legislature further believes that physicians and nurses should not withhold or unreasonably diminish pain medication for patients in a terminal condition where the primary intent of providing such medication is to alleviate pain and maintain or increase the patient's comfort.

The legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining treatment where the patient

having the capacity to make health care decisions has voluntarily evidenced a desire that such treatment be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the legislature hereby declares that the laws of the state of Washington shall recognize the right of an adult person to make a written directive instructing such person's physician to withhold or withdraw life-sustaining treatment in the event of a terminal condition or permanent unconscious condition. The legislature also recognizes that a person's right to control his or her health care may be exercised by an authorized representative who validly holds the person's durable power of attorney for health care.

RCW 70.122.020 Definitions.

Unless the context clearly requires otherwise, the definitions contained in this section shall apply throughout this chapter.

(1) "Adult person" means a person who has attained the age of majority as defined in RCW 26.28.010 and 26.28.015, and who has the capacity to make health care decisions.

(2) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(3) "Directive" means a written document voluntarily executed by the declarer generally consistent with the guidelines of RCW 70.122.030.

(4) "Health facility" means a hospital as defined in RCW 70.41.020(2) or a nursing home as defined in RCW 18.51.010, a home health agency or hospice agency as defined in RCW 70.126.010, or a boarding home as defined in RCW 18.20.020.

(5) "Life-sustaining treatment" means any medical or surgical intervention that uses mechanical or other artificial means, including artificially provided nutrition and hydration, to sustain, restore, or replace a vital function, which, when applied to a qualified patient, would serve only to prolong the process of dying. "Life-sustaining treatment" shall not include the administration of medication or the performance of any medical or surgical intervention deemed necessary solely to alleviate pain.

(6) "Permanent unconscious condition" means an incurable and irreversible condition in which the patient is medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(7) "Physician" means a person licensed under chapters 18.71 or 18.57 RCW.

(8) "Qualified patient" means an adult person who is a patient diagnosed in writing to have a terminal condition by the patient's attending physician, who has personally examined the patient, or a patient who is diagnosed in writing to be in a permanent unconscious condition in accordance with accepted medical standards by two physicians, one of whom is the patient's attending physician, and both of whom have personally examined the patient.

(9) "Terminal condition" means an incurable and irreversible condition caused by injury, disease, or illness, that, within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW 70.122.030 Directive to withhold or withdraw life-sustaining treatment.

(1) Any adult person may execute a directive directing the withholding or withdrawal of life-sustaining treatment in a terminal condition or permanent unconscious condition. The directive shall be signed by the declarer in the presence of two witnesses not related to the declarer by blood or marriage and who would not be entitled to any portion of the estate of the declarer upon declarer's decease under any will of the declarer or codicil thereto then existing or, at the time of the directive, by operation of law then existing. In addition, a witness to a directive shall not be the attending physician, an employee of the attending physician or a health facility in which the declarer is a patient, or any person who has a claim against any portion of the estate of the declarer upon declarer's decease at the time of the execution of the directive. The directive, or a copy thereof, shall be made part of the patient's medical records retained by the attending physician, a copy of which shall be forwarded by the custodian of the records to the health facility when the withholding or withdrawal of life-support treatment is contemplated. The directive may be in the following form, but in addition may include other specific directions:

Health Care Directive

Directive made this . . . . day of . . . . . (month, year).

I . . . . . ., having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

(a) If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians,

and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

(b) In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of my desires.

(c) If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one):

I DO want to have artificially provided nutrition and hydration.

I DO NOT want to have artificially provided nutrition and hydration.

(d) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall

have no force or effect during the course of my pregnancy.

(e) I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

(f) I understand that before I sign this directive, I can add to or delete from or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

(g) It is my wish that every part of this directive be fully implemented. If for any reason any part is held invalid it is my wish that the remainder of my directive be implemented.

Signed.....

City, County, and State of Residence

The declarer has been personally known to me and I believe him or her to be capable of making health care decisions.

Witness.....

Witness.....

(2) Prior to withholding or withdrawing life-sustaining treatment, the diagnosis of a terminal condition by the attending physician or the diagnosis of a permanent unconscious state by two physicians shall be entered in writing and made a permanent part of the patient's medical records.

(3) A directive executed in another political jurisdiction is valid to the extent permitted by Washington state law and federal constitutional law.

RCW 70.122.040 Revocation of directive.

(1) A directive may be revoked at any time by the declarer, without regard to declarer's mental state or competency, by any of the following methods:

(a) By being canceled, defaced, obliterated, burned, torn, or otherwise destroyed by the declarer or by some person in declarer's presence and by declarer's direction.

(b) By a written revocation of the declarer expressing declarer's intent to revoke, signed, and dated by the declarer. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time and date when said physician received notification of the written revocation.

(c) By a verbal expression by the declarer of declarer's intent to revoke the directive. Such revocation shall become effective only upon communication to the attending physician by the declarer or by a person acting on behalf of the declarer. The attending physician shall record in the patient's medical record the time, date, and place of the revocation and the time, date, and place, if different, of when said physician received notification of the revocation.

(2) There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless that person has actual or constructive knowledge of the revocation.

(3) If the declarer becomes comatose or is rendered incapable of communicating with the attending physician, the directive shall remain in effect for the duration of the

comatose condition or until such time as the declarer's condition renders declarer able to communicate with the attending physician.

RCW 70.122.051 Liability of health care provider or facility.

Any physician, health care provider acting under the direction of a physician, or health facility and its personnel who participate in good faith in the withholding or withdrawal of life-sustaining treatment from a qualified patient in accordance with the requirements of this chapter, shall be immune from legal liability, including civil, criminal, or professional conduct sanctions, unless otherwise negligent.

RCW 70.122.060 Procedures by physician—Health care facility or personnel may refuse to participate.

(1) Prior to the withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the directive, the attending physician shall make a reasonable effort to determine that the directive complies with RCW 70.122.030 and, if the patient is capable of making health care decisions, that the directive and all steps proposed by the attending physician to be undertaken are currently in accord with the desires of the qualified patient.

(2) The attending physician or health facility shall inform a patient or patient's authorized representative of the existence of any policy or practice that would preclude the honoring of the patient's directive at the time the physician or facility becomes aware of the existence of such a directive. If the patient, after being informed of such policy or directive, chooses to retain the physician or facility, the physician or facility with the patient or the patient's representative shall prepare a written plan to be filed with the patient's directive that sets forth the physician's or facilities' intended actions should the

patient's medical status change so that the directive would become operative. The physician or facility under this subsection has no obligation to honor the patient's directive if they have complied with the requirements of this subsection, including compliance with the written plan required under this subsection.

(3) The directive shall be conclusively presumed, unless revoked, to be the directions of the patient regarding the withholding or withdrawal of life-sustaining treatment. No physician, health facility, or health personnel acting in good faith with the directive or in accordance with the written plan in subsection (2) of this section shall be criminally or civilly liable for failing to effectuate the directive of the qualified patient pursuant to this subsection.

(4) No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's participation or refusal to participate in the withholding or withdrawal of life-sustaining treatment.

RCW 70.122.070 Effects of carrying out directive—Insurance.

(1) The withholding or withdrawal of life-sustaining treatment from a qualified patient pursuant to the patient's directive in accordance with the provisions of this chapter shall not, for any purpose, constitute a suicide or a homicide.

(2) The making of a directive pursuant to RCW 70.122.030 shall not restrict, inhibit, or impair in any manner the sale, procurement, or issuance of any policy of life insurance, nor shall it be deemed to modify the terms of an existing policy of life insurance. No policy of life

insurance shall be legally impaired or invalidated in any manner by the withholding or withdrawal of life-sustaining treatment from an insured qualified patient, notwithstanding any term of the policy to the contrary.

(3) No physician, health facility, or other health provider, and no health care service plan, insurer issuing disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan, shall require any person to execute a directive as a condition for being insured for, or receiving, health care services.

RCW 70.122.080 Effects of carrying out directive on cause of death.

The act of withholding or withdrawing life-sustaining treatment, when done pursuant to a directive described in RCW 70.122.030 and which results in the death of the declarer, shall not be construed to be an intervening force or to affect the chain of proximate cause between the conduct of anyone that placed the declarer in a terminal condition or a permanent unconscious condition and the death of the declarer.

RCW 70.122.090 Criminal conduct—Penalties.

Any person who willfully conceals, cancels, defaces, obliterates, or damages the directive of another without such declarer's consent shall be guilty of a gross misdemeanor. Any person who falsifies or forges the directive of another, or willfully conceals or withholds personal knowledge of a revocation as provided in RCW 70.122.040 with the intent to cause a withholding or withdrawal of life-sustaining treatment contrary to the wishes of the declarer, and thereby, because of any such act, directly causes life-sustaining treatment to be withheld or withdrawn and death to thereby be hastened, shall be subject to prosecution for murder in the first degree as defined in RCW 9A.32.030.

RCW 70.122.100 Mercy killing or physician-assisted suicide not authorized.

Nothing in this chapter shall be construed to condone, authorize, or approve mercy killing or physician-assisted suicide, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying.

RCW 70.122.110 Discharge so that patient may die at home.

If a qualified patient capable of making health care decisions indicates that he or she wishes to die at home, the patient shall be discharged as soon as reasonably possible. The health care provider or facility has an obligation to explain the medical risks of an immediate discharge to the qualified patient. If the provider or facility complies with the obligation to explain the medical risks of an immediate discharge to a qualified patient, there shall be no civil or criminal liability for claims arising from such discharge.

RCW 70.122.120 Directive's validity assumed.

Any person or health facility may assume that a directive complies with this chapter and is valid.

RCW 70.122.900 Short title.

This act shall be known and may be cited as the "Natural Death Act".

RCW 70.122.910 Construction.

This chapter shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, including but not limited to, the withholding or withdrawal of life-sustaining treatment, nor limiting the means provided by case law more expansive than chapter 98, Laws of 1992.

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No. 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENTS

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QUESTIONS PRESENTED

Whether the Fourteenth Amendment's guarantee of liberty protects the decision of a mentally competent, terminally ill adult to bring about impending death in a certain, humane, and dignified manner?

Whether a state denies equal protection when it permits terminally ill patients who are on life support to choose a humane death with medical assistance but prohibits terminally ill patients who are not on life support from exercising the same right by self-administering medication prescribed for that purpose?

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OPINIONS BELOW

Respondents concur in petitioners' statement.

JURISDICTION

Respondents concur in petitioners' statement.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Respondents concur in petitioners' statement.

STATEMENT OF THE CASE

The State of Washington has recognized a "fundamental right" of a competent, terminally ill patient to exercise "individual autonomy" to end a painful, dehumanizing, and extended process of dying. Wash. Rev. Code § 70.122.010. To that end, the State has made lawful the withdrawal of medical treatment and hydration and nutrition for the purpose of hastening death at the request of such patients. Wash. Rev. Code § 70.122.051. A preexisting state law, however, makes it a crime to aid another person to attempt suicide. Wash. Rev. Code § 9A.36.060. This law applies to physicians who respond to a mentally competent, terminally ill patient's choice to avoid an extended course of dying by prescribing medications that the patient can choose to take to bring about impending death. This case challenges that application as a denial of liberty and of equal protection.

The record establishes these undisputed facts regarding the plaintiff patients and physicians:

At the time the complaint was filed, the plaintiff who used the pseudonym Jane Roe was dying of breast cancer.[1] She was 69, a retired pediatrician. Her cancer had metastasized widely and was growing rapidly throughout her entire skeleton. She had undergone surgery, chemotherapy, and radiation therapy, but the cancer prevailed. Dr. Roe suffered chronic, intractable pain, which she attempted to alleviate with large and increasing doses of morphine. She still experienced frequent and severe pain. Dr. Roe was confined to bed for the seven months prior to the filing of this action. Movement was intensely painful, and her weakened muscles could not support her. She was anemic, incontinent, and vulnerable to infection.

Dr. Roe was mentally competent. She had been advised and, as a doctor, fully understood that there was no chance of recovery and that, despite excellent medical care, she faced severe and unrelenting suffering. Dr. Roe wished to hasten her impending death by taking drugs of a type and in an amount prescribed by her doctor for that purpose. *Compassion in Dying v. Washington*, 79 F.3d 790, 794-95 (CA9 1996) (en banc); Appendix to Petition for Writ of Certiorari (Pet. App.) A-10 to A-13. (The undisputed declarations of the patients and doctors appear in the Joint Appendix (JA) 22-75 and 187-228.)

Plaintiff John Doe, 44, was dying of AIDS. His doctors had advised him that there was no chance of recovery and that

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[1] Dr. Roe died a month after the filing of the lawsuit, and the other two patient-plaintiffs died within the following months. *See Compassion in Dying v. Washington*,79 F.3d 790, 794-95 (CA9 1996) (en banc); Appendix to Petition for Writ of Certiorari (Pet. App.) A-10 to A-13.

he faced severe and continuous suffering. Mr. Doe was vulnerable to all manner of infection. He had cytomegalovirus retinitis, which had caused him to lose approximately 70 percent of his vision and was anticipated to soon result in complete blindness. Mr. Doe had been hospitalized for AIDS-related pneumonia on several occasions; suffered from chronic skin infections, sinusitis, and grand mal seizures related to AIDS; and experienced extreme fatigue and a rapidly diminishing ability to care for himself. Mr. Doe had served as the primary caregiver for his long-term companion who died of AIDS at home. Mr. Doe witnessed firsthand the pain, suffering, and loss of bodily function, integrity, and personal dignity that the disease causes at the end of life.

Mr. Doe was mentally competent and understood his diagnosis and prognosis. He wished to hasten his impending death by taking drugs prescribed by his doctor. *Id.*

Plaintiff James Poe, 69, was dying of emphysema. His doctors had advised him that he had no chance of recovery. Every breath was a struggle. He was tethered to an oxygen tube 24 hours a day. He spent hours each day aspirating medications to facilitate breathing. He was terrified by his "constant sensation of suffocation." He regularly took morphine and other medications to calm his "terror." He also suffered from associated heart failure, which resulted in painful swelling of his extremities and loss of mobility. "The only comfortable times are when I am asleep. However, I have difficulty sleeping longer than two to three hours at a time." JA 30.

Mr. Poe was mentally competent and understood his diagnosis and prognosis. He too desired the right to hasten his impending death by taking drugs prescribed by his doctor for that purpose when his suffering became unbearable. 79 F.3d at 794-95; Pet. App. A-10 to A-13.

Respondents Glucksberg, Halperin, Preston, and Shalit are physicians who regularly treat terminally ill patients. Each encounters mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and who desire physician assistance in dying to avoid prolonged suffering. Each feels a professional responsibility to honor a competent, voluntary, and personal choice in the face of death to hasten that death and reduce suffering. The physicians present both their own claims and the claims of their patients.[2] *Id.*

In the physicians' professional judgment, the desire of such patients to hasten impending death and avoid continued suffering can be rational. Each physician-plaintiff believes that before prescribing drugs that the patient could choose whether to take to bring about death, the appropriate procedure is to ensure that the patient is competent, is acting voluntarily, and is in the terminal phase of illness. Where this has been done and the patient still seeks a humane and dignified death, these doctors wish to prescribe drugs that will allow the patient to decide whether to live, and suffer, any longer. It was undisputed below that patients who cannot receive this medical assistance cannot hasten their deaths in a certain and humane manner and that some cannot hasten their death in any manner without such assistance. The physicians, however, know that prescribing drugs for this purpose exposes them to criminal prosecution under Wash. Rev. Code § 9A.36.060. *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1457-58 (W.D. Wash. 1994); Pet. App. E-4 to E-7.

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[2] The State does not challenge the Ninth Circuit's holding that the physicians, who sued on their own behalf and on behalf of their mentally competent, terminally ill patients, have standing to present the claims of such patients. 79 F.3d at 795-96; Pet. App. A-13 to A-15; *see, e.g., Planned Parenthood of Mo. v. Danforth*, 428 U.S. 52, 62 (1976).

As a result, the physicians have witnessed their patients suffer terrible ordeals. One of Dr. Glucksberg's mentally competent, terminally ill patients, who was in excruciating pain and did not want to end his days in a lingering drug-induced stupor, requested medication he could self-administer to hasten his impending death. Constrained by the criminal statute, Dr. Glucksberg was forced to refuse this request. The patient enlisted one of his family members to help him climb over a bridge railing to jump to his death. JA 35-36.

A competent patient of Dr. Halperin's with advanced terminal breast cancer, who had been fiercely self-sufficient throughout her lifetime, and who rejected living her final days in a dependent and undignified manner, requested medications she could take to hasten her death. Dr. Halperin was forced to reject this request. The patient suffocated herself by securing a plastic bag over her head. JA 50-51.

A mentally competent AIDS patient requested Dr. Shalit to prescribe medications he could self-administer to hasten a more gentle death. The criminal prohibition forced Dr. Shalit to deny the request and to stand by as the patient endured an excruciating and lingering death. Oozing lesions from his cancer prevented him from walking or urinating. His fingers were gangrenous. The patient's loved ones found his condition so horrifying that they could not bear to visit and witness his physical torture. JA 74-75.[3]

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[3] The experiences of these patients are in no way unique. The Brief Amici Curiae of Surviving Family Membe.s in Support of Respondents details similar experiences. *See also* Timothy E. Quill, *Death and Dignity* (1993); Timothy E. Quill, *A Midwife Through the Dying Process* (1996); Lonny Shavelson, *A Chosen Death* (1995); Betty Rollin, *Last Wish* (1996); Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* (1993).

These patients and physicians were not "hypothetical," *cf.* Brief for the Petitioners at 39,[4] and they filed suit in the United States District Court for the Western District of Washington, challenging the application of Section 9A.36.060 to them. On cross motions for summary judgment, with the State accepting all of plaintiffs' factual allegations, the District Court held that Section 9A.36.060 abridges rights secured by the United States Constitution, specifically liberty and equal protection guaranteed by the Fourteenth Amendment. 850 F. Supp. at 1467; Pet. App. E-28 to E-29. The Ninth Circuit, sitting en banc, affirmed the liberty analysis in an exhaustive opinion joined by eight judges. 79 F.3d at 813-16; Pet. App. A-56 to A-62. The Ninth Circuit did not reach the equal protection claim. *Id.* at 838; Pet. App. A-115. One month later, the Second Circuit invalidated similar application of a New York statute on equal protection grounds. *Quill v. Vacco*, 80 F.3d 716, 727 (CA2), *cert. granted*, No. 95-1858 (1996).

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[4] Petitioners never suggested below that these patients were less than real and never contested their conditions or the ability of their doctors to accurately assess whether they were in the terminal stage and whether they were competent. The challenged statute operated to prevent patient-plaintiffs Roe, Doe, and Poe — and operates to prevent the mentally competent, terminally ill patients of the physician-plaintiffs — from exercising the option of a humane, hastened death. Having found the statute unconstitutional as applied to these individuals, the court below properly concluded that the constitutional infirmity would exist as well in the case of individuals similarly situated. 79 F.3d at 798 n.9; Pet. App. A-20 to A-21.

SUMMARY OF ARGUMENT

I. INDIVIDUAL LIBERTY PROTECTED BY THE FOURTEENTH AMENDMENT INCLUDES CONTROL OF ONE'S FINAL DAYS

The Court has consistently recognized that the guarantee of liberty in the Fourteenth Amendment extends to life-shaping decisions that individuals make about their bodies and futures. Forcing a patient to suffer through an extended process of dying controls that person's remaining life and denies the patient's choice to cross the threshold of death in a manner consistent with her conscience and values. The State ought not intrude into and dictate this profoundly personal decision, forcing the patient-plaintiffs to endure painful and undignified deaths.

The State enforces an absolute prohibition on patient choice in a context where the State's legitimate concerns would be adequately, indeed better, addressed through regulation. Recognizing a dying patient's liberty to choose how to die in no way suggests that the State lacks a valid interest in protecting against usurpation of the dying patient's wishes by others. To say that the State must respect the individual's autonomy does not imply that the State must stand by while others try to extinguish such autonomy or that the State must allow an incompetent or coerced patient to die. The State may establish reasonable safeguards to assure that the patient is competent and has in fact reached the terminal phase of illness.

II. DENYING ASSISTANCE IN DYING TO TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT VIOLATES EQUAL PROTECTION

Washington law recognizes the same right at issue in this case, but only for a certain class of mentally competent, terminally ill patients — those whose lives depend upon contin-

ued medical intervention. Physicians who comply with requests by terminally ill patients to withdraw treatment, even where the patient's express intention is thereby to hasten death, are immune from prosecution under the challenged statute. Some terminally ill patients thus are able to choose to hasten impending death with medical assistance. This discrimination between terminally ill patients whose condition involves life-sustaining treatment and those whose condition does not involve such treatment violates the Equal Protection Clause of the Fourteenth Amendment.

ARGUMENT

Wash. Rev. Code § 9A.36.060 was enacted in 1854. It provides in relevant part that a person is guilty of a crime if he or she "knowingly . . . aids another person to attempt suicide."[5] The Washington Supreme Court and the Washington

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[5] Respondents do not challenge the portion of the statute that prohibits "knowingly caus[ing] another person to attempt suicide," which would include undue influence or assisting in the suicide of a patient who was not mentally competent or who was known to be under a misapprehension as to such material facts as diagnosis and prognosis. *See, e.g., State v. Jamison*, 94 Wash. 2d 663, 619 P.2d 352 (1980) (defendant promoted suicide by abusing cellmate). Some amici urge that the challenged statute does not reach the conduct of a physician in prescribing medications for a competent, dying patient to use to hasten death. *E.g.*, Brief Amici Curiae of Bioethicists in Support of Petitioners at 15 n.6. The State obviously disagrees and has expressed its intent to prosecute, thus deterring physicians from responding to the requests of these patients. It is true that the State has, in the name of federalism, claimed various purposes nowhere mentioned by the Washington Legislature and contrary to the legislative findings in Wash. Rev. Code § 70.122.010 and the Washington court decisions that preceded that statute. It should not be assumed that the State, as opposed to state lawyers, accepts those interests or finds that they outweigh the liberty at stake. For these reasons, Judge Calabresi in *Quill* suggested in his concurrence that a sensible course would be to strike the statute down as

Legislature have created effective exceptions to Section 9A.36.060 for those on life-sustaining treatment. Section 70.122.080 created an exception for withdrawal of life support, and in Section 70.122.010 the Legislature recognized the fundamental rights at issue here. Nonetheless, the State contends that the statute reaches physicians who respond to the requests of their competent, dying patients by prescribing drugs that the patients can use, when and if they so choose, to shape and control their imminent and inevitable death.

Since 1854, the art and science of medicine have advanced dramatically. Lifespans have been extended, and the dying process frequently proceeds less rapidly than once was the case.[6] A series of court decisions and statutes permit competent patients undergoing an intolerable process of dying to direct the termination of life support, and thereby hasten death. Other patients, similarly facing imminent death, have conditions that are not susceptible to such treatments, and thus to the termination of such treatments. They are equally at a terminal stage, but their conditions do not interfere with respiration, nutrition, or hydration. Those patients now ask for protection of their liberty, and for the same rights as other patients are afforded.

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unconstitutional but allow the legislature to consider whether it in fact desired to prohibit the conduct alleged to be protected. The legislature could seek passage of a suitably explicit measure, which could then be reviewed for constitutional sufficiency. *Quill*, 80 F.3d at 738-43 (Calabresi, J., concurring).

[6] *See* Brief Amici Curiae of Bioethics Professors Supporting Respondents; Howard Brody, *Assisted Death—A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) (modern medical technology extends lives but leaves patients with an unacceptable way of dying).

I. THE CHALLENGED STATUTE INFRINGES THE LIBERTY OF COMPETENT, TERMINALLY ILL ADULTS TO MAKE END-OF-LIFE DECISIONS FREE OF UNDUE GOVERNMENT INTERFERENCE

A. A Competent, Terminally Ill Patient's End-of-Life Decision Is Within the Court's Interpretation of Liberty as Including Basic and Intimate Exercises of Personal Autonomy

This case calls upon the Court to address once again the limits of government power and the scope of individual autonomy. The Fourteenth Amendment provides that the State may not "deprive any person of life, liberty, or property, without due process of law." The scope of liberty, the "least specific and most comprehensive protection," is not clear from the face of the Constitution. *Rochin v. California*, 342 U.S. 165, 170 (1952). The Court has applied the term to many different situations. *See Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting) ("[L]iberty is not a series of isolated points pricked out . . . . It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . ."). In analyzing "liberty," the Court has heeded the directive of the Ninth Amendment that the rights of the people are not to be disparaged merely because every aspect could not be explicitly captured in constitutional text. *See Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992); *Griswold v. Connecticut*, 381 U.S. 479, 488-92 (1965) (Goldberg, J., concurring) (recognizing Ninth Amendment rule of construction that substance of liberty protected against state action by the Fourteenth Amendment is not exhausted by specific rights enumerated in the first eight amendments).

Just four years ago, in addressing one of the most persistent and difficult issues that it has ever confronted, the Court stated resoundingly:

> It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter.

Casey, 505 U.S. at 847.[7] The Court accepted that there is a core of individuality that the state is bound to respect under the Fourteenth Amendment, and the Court recognized that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education." *Id.* at 851. In *Casey*, the Court reviewed its liberty jurisprudence and noted:

> It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, [410 U.S. 113 (1973)], that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, *see Carey v. Population Services International*, [431 U.S. 678 (1977)]; *Moore v. East Cleveland*, 431 U.S. 494 . . . (1977); *Eisenstadt v. Baird*, [405 U.S. 438 (1972)]; *Loving v. Virginia*, [388 U.S. 1 (1967)]; *Griswold v. Connecticut*, [381 U.S. 479 (1965)]; *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 . . . (1942); *Pierce v. Society of Sisters*, [268 U.S. 510 (1925)]; *Meyer v. Nebraska*, [262 U.S. 390 (1923)], as well as bodily integrity. *See, e.g., Washington v. Harper*,

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[7] The State denies the applicability of *Casey*, seeking to limit to the abortion context the principles *Casey* enunciated and characterizing its holding as compelled by stare decisis. *See, e.g.*, Brief for the Petitioners at 31-32. *Casey*, says the State, is not worthy of stare decisis because it relied only upon stare decisis. To the contrary, *Casey* crafted a reliable, measured course for the future, and the reasoning of *Casey* applies with full force to the present case.

> 494 U.S. 210, 221-222 . . . (1990); *Winston v. Lee*, 470 U.S. 753 . . . (1985); *Rochin v. California*, 342 U.S. 165 . . . (1952).

505 U.S. at 849.

The holdings cited by the Court in *Casey* arise from the fact that our society has historically afforded individuals the right to make personal decisions regarding their own bodies, medical care, and, fundamentally, the future course of their lives. As Justice Powell said for the Court in one of the cases underlying *Casey*, "unless we close our eyes to the basic reasons why certain rights . . . have been accorded shelter under the Fourteenth Amendment's Due Process Clause, we cannot avoid applying the force and rationale of these precedents to the . . . choice involved in this case." *Moore v. East Cleveland*, 431 U.S. 494, 501 (1977). The liberty at issue here is another element of self-sovereignty and is of comparable importance to that involved in *Casey*.

Indeed, the Court's discussion in *Casey* as to why the Constitution protects various personal decisions applies with full force to end-of-life decisions:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

505 U.S. at 851. "Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* Finally, *Casey* recognizes that

the State's authority to insist that an individual endure suffering is quite limited. *Id.* at 852.

In the decision below, the Ninth Circuit correctly found that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." 79 F.3d at 813; Pet. App. A-55 to A-56. Few would deny that "no decision is more painful, delicate, personal, important, or final than the decision how and when one's life shall end." *Id.* at 837; Pet. App. A-113. The Ninth Circuit recognized that

> For such patients, wracked by pain and deprived of all pleasure, a state-enforced prohibition on hastening their deaths condemns them to unrelieved misery or torture. Surely, a person's decision whether to endure or avoid such an existence constitutes one of the most, if not the most, "intimate and personal choices a person may make in a life-time," a choice that is "central to personal dignity and autonomy."

Id. at 814; Pet. App. A-57 to A-58 (quoting *Casey*, 505 U.S. at 851). Moreover, as the Ninth Circuit noted and as is discussed at greater length *infra* with respect to equal protection, the State of Washington has recognized a "fundamental right" in making end-of-life decisions, and has determined that the State's interest in preserving life is either not implicated or should ordinarily give way to the wishes of a competent, terminally ill patient. *Id.* at 817; Pet. App. A-65 to A-67.

For many patients suffering through an intolerable process of dying, "being forced to live is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life . . . . It is a life almost totally occupied." Jed Rubenfeld, *The Right of Privacy*, 102 Harv. L. Rev. 737, 788,

795 (1989). That is certainly true for the patient-plaintiffs. As Dr. Roe stated:

> I have been almost entirely bedridden due to a combination of pain associated with the cancer in my bones and the diminishing strength in my muscles as I use them less and less. I am now unable to walk or use the commode or a bed pan without assistance. My legs are swollen with severe edema and I can scarcely use them. I have developed bed sores as a result of being bed bound. My appetite is poor and I take medications to prevent nausea and vomiting. My vision is often impaired. My left hand is weak. Drowsiness is a frequent problem. I have an indwelling urinary catheter and am sometimes incontinent of bowel.
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> . . . The pain associated with this cancer is unrelenting. It is a constant, dull pain, interspersed with sharp, severe pain provoked by movement. The site of pain moves as the disease advances. . . . I take a variety of medications to manage pain. There is a tension between taking enough medication to alleviate the pain and retaining an alert mental state. It is not possible to eliminate my pain and for me to retain an alert state.

JA 23-24. Liberty certainly reaches laws that operate to "occupy" lives such as that of Dr. Roe, confining them into a painful and dependent condition.

People treat the manner of their death as of special, symbolic importance and want their deaths to confirm their own values. The moment and circumstances of death can be of profound significance. *See* Brief Amici Curiae of Religious

Organizations and Leaders in Support of Respondents. Control over one's final circumstances, especially because it is the last exercise of autonomy, is an intensely personal decision at a very private time. The fundamental protection from state intrusion into basic personal decisions as to the course of one's life limits the state's power to dictate this most intimate choice: the selection and implementation within the doctor-patient relationship of appropriate treatment at the end of life.

To deny a competent, dying patient the right to choose a humane, dignified death is to condemn the individual to live the final chapter of life in a state-controlled and state-approved manner. This plainly has "life long spiritual, moral and psychological" consequences both for the patient and loved ones who bear witness. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 14. Forcing a patient to endure a painful and dehumanizing dying process is fraught with cruelty to the patient and anguish to loved ones. *See id.* at 14 (citing *Casey*, 505 U.S. at 853). Accordingly, even the Solicitor General agrees that this is a protected liberty. Brief for the United States as Amicus Curiae Supporting Petitioners at 12-16.

Although the end-of-life decision is not explicitly discussed in the Constitution, the Court in *Casey* reaffirmed that the liberty protected by the Due Process Clause encompasses more than the rights guaranteed by the express provisions of the first eight amendments, and may well include protection of conduct that was illegal at the time the Fourteenth Amendment was ratified. 505 U.S. at 847. *Casey* decisively rejected the notion that illegality at the time the Fourteenth Amendment was ratified precludes recognition of a protected liberty. *Id.* As Justice O'Connor has noted, "due process is not a technical concept with a fixed content unrelated to time, place, and circumstances. . . . The Constitution . . . requires judges to examine even traditionally accepted procedures and, if necessary, to declare them invalid." Sandra D. O'Connor,

Conference on Compelling Government Interests, 55 Alb. L. Rev. 535, 542 (1992). Historical protection is a sufficient but not a necessary condition to recognition of an additional aspect of liberty.

Thus, the Second Circuit's reluctance in *Quill v. Vacco* to recognize the dying patient's liberty was based on the mistaken understanding that *Bowers v. Hardwick*, 478 U.S. 186 (1986), directs lower courts to refrain from recognizing new aspects of liberty, even where this Court's analytical standards have been met. 80 F.3d at 725.[8] This Court has long accepted its duty to apply the concept of liberty to appropriate situations that it had not previously been called upon to address, just as a "prime part of the history of our Constitution . . . is the story of the extension of constitutional rights and protections to people once ignored or excluded." *United States v. Virginia*, 116 S. Ct. 2264, 2287 (U.S. 1996).

The State argues that the cases recognizing various aspects of liberty are distinguishable because they involve activities allowing the individual "a broader participation in life and

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[8] The Second Circuit's deferral to this Court betrayed no disagreement with respondents that the fundamental personal decision at stake here is within the core of protected individual liberty:

> [W]hat business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define her own concept of existence, of meaning, of the universe, and of the mystery of human life" . . . when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

80 F.3d at 730 (quoting *Casey*, 505 U.S. at 851).

society" or, conversely, because they are limited to a right to be free of bodily invasion. Brief for the Petitioners at 26-27. This contention is unpersuasive. Those cases consistently protect decisions arising at key points in one's life, decisions that help define and shape that life. Few of the cases, and certainly not the abortion decisions, involve direct bodily intrusion. The decision how to die is the final life-shaping decision a person can make, and is as important, personal, and private as other decisions the Constitution protects from state domination. The circumstances certainly narrow a dying patient's participation in life and society, but the right at issue here broadens the patient's control over what is left of such participation. Any element of control during those last days is precious. Many of the Court's liberty decisions have not involved a person's desire to enjoy broader participation; in fact, some have involved the individual's right to choose among quite unpleasant alternatives. *E.g.*, *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990); *Washington v. Harper*, 494 U.S. 210 (1990); *Rochin v. California*, 342 U.S. 165 (1952).

Several of the State's amici devote their briefs to the history of proscriptions against suicide. The Court in *Casey* decisively rejected any general rule that liberty is limited to historically and traditionally protected rights. 505 U.S. at 847-50; *see Rochin*, 342 U.S. at 171 (rights cannot be frozen "at some fixed stage of time or thought"); *Roe*, 410 U.S. at 118 (most states had abortion prohibitions similar to that of Texas). More specifically, in *Cruzan* the Court effectively rejected Justice Scalia's contention that state laws prohibiting suicide precluded the recognition of a right to hasten death by directing the removal of life support. The proper question is whether society, and the Court's constitutional interpretation, has afforded individuals the right to make personal decisions

regarding their bodies, medical care, and life-course without burdensome government intrusion.[9] The answer is plainly yes.

Further, history reflects a growing trend in favor of the terminally ill patient's control of end-of-life decision-making. *See Compassion*, 79 F.3d at 821-22; Pet. App. A-75 to A-77. Indeed, many of the state court decisions dealing with the patient's right to hasten death by deciding to terminate medical care have recognized that right as not self-contained but as one aspect of the common law protection of self-determination and personal autonomy. *E.g.*, *In re Gardner*, 534 A.2d 947, 950 (Me. 1987); *In re Conroy*, 486 A.2d 1209, 1221-23 (N.J. 1985). The Washington Supreme Court held that such principles were fundamental to the common law and to the state (and federal) constitution. *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 741-42 (1983); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1376 (1984); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987).

It is true that, for many people in our society, a competent, terminally ill person's liberty to shape death in this manner raises religious implications, just as does abortion.[10] Religious

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[9] Even if the historical inquiry focuses on the act of suicide or assisted suicide, the Ninth Circuit is correct that the historical record is checkered. 79 F.3d at 806-10; Pet. App. A-39 to A-47; *see* Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 373-75 (1992).

[10] *See, e.g.*, Brief Amici Curiae of Metropolitan Catholic Physicians Guild in Support of Petitioners at 14-23; Brief Amicus Curiae of Evangelical Lutheran Church in America in Support of Petitioners at 1-3, 22-24; Brief Amici Curiae of Catholic Health Association in Support of Petitioners at 16-18. *See generally* Matthew P. Previn, *Assisted Suicide and Religion, Conflicting Conceptions of the Sanctity of Human Life*, 84 Geo. L.J. 589 (1996).

objections to the exercise of individual liberty, however, are reason to leave such issues to individual conscience, not the state. *See* Brief Amicus Curiae of Religious Organizations and Leaders in Support of Respondents. As recognized by the Court in *Casey*, religious concerns about a liberty

> cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code. The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a [person] lacks all choice in the matter
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> . . . .

505 U.S. at 850; *see Poe v. Ullman*, 367 U.S. at 545 (Harlan, J., dissenting) ("the mere assertion that the action of the State finds justification in the controversial realm of morals cannot justify alone any and every restriction it imposes").

Here, the question is whether the State can resolve the philosophical questions relating to the end of life so definitively that competent, terminally ill adults lack any choice in the matter. The answer, consistent with the Fourteenth Amendment, must be no. To hold otherwise would necessarily mean that the State's religious or philosophical preference outweighs that of the competent, dying patient. By compelling individuals to endure suffering at the end of their lives, the state devalues the nobility of the free will and faith that many would otherwise show in willingly accepting the circumstances of death, no matter how painful and humiliating.

The State attempts to distinguish the decision to seek assistance in dying from the decision to have an abortion on the grounds that "the decision whether to have a child . . . is

something over which humans can exercise a great deal of personal autonomy." Brief for the Petitioners at 28. This is circular and inconsistent. Absent the State's interference, a terminally ill patient could exercise the full measure of autonomy that the circumstances allow over how and when to die, and such autonomy is today legal with respect to the decision to accept, forgo, or withdraw life-sustaining treatment.

Similarly flawed is the Solicitor General's attempt to distinguish the abortion cases on the grounds that the decision to abort implicates a "combination" or "constellation" of interests. Brief for the United States as Amicus Curiae Supporting Petitioners at 15.[11] The United States recognizes that both abortion and the present case implicate a desire to avoid pain and suffering, but argues that the abortion equation involves much more than that. Avoidance of suffering, while undoubtedly significant here, is still but one part of a terminally ill patient's decision to die in a humane and dignified manner. The equation here includes the freedoms to exercise conscience and personal autonomy, to avoid irreversible bodily disintegration, to choose the course of one's life, and to subscribe to a philosophy about the end of life that is different from that of the 19th century Washington legislature that enacted the statute now at issue.

The American Medical Association asserts that pain management can ease one form of suffering, physical pain, and

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[11] The Solicitor General's argument that abortion precedent is premised on principles of gender equality is inaccurate. While the Court recognized an equality component in liberty, which is also important here, the Court has always found the right of reproductive choice to be protected as a matter of human liberty, and not just as a matter of gender equality. *E.g. Casey*, 505 U.S. at 851, 853; *Carey*, 431 U.S. at 684-86; *Roe*, 410 U.S. at 152-53; *Eisenstadt*, 405 U.S. at 453; *Griswold*, 381 U.S. at 485-86.

reduce many patients' desire for a hastened death. Brief Amicus Curiae of American Medical Association in Support of Petitioners at 10. The State can act to assure that inadequately treated pain does not motivate the choice of a hastened death. Successful pain management, however, would at most mitigate for some patients the need to exercise the liberty in question. Even where pain management is successful, *Casey* and *Cruzan* make clear that liberty is not limited to the avoidance of pain, especially when avoidance is accomplished with medication that reduces control over mind and body, thus imposing on the patient even more incapacity and increasing the suffering from feelings of degradation and helplessness. Moreover, the undisputed factual record of this case is that medical science cannot sufficiently ease the physical pain of the patient-plaintiffs and many others. JA 34-35, 49, 73. *See also* Brief of Coalition of Hospice Professionals as Amicus Curiae for Affirmance of the Judgments Below.

The AMA concedes this and suggests that, where pain cannot be alleviated, the doctor can sedate the patient "to a sleep-like state" until she dies of starvation or dehydration "days or weeks" later. Brief Amicus Curiae of American Medical Association in Support of Petitioners at 6.[12] This "terminal sedation" option — voluntarily submitting to a drug-induced coma while one's body disintegrates and loved ones stand vigil — is monstrous to many patients. Moreover, a patient sedated in this manner might only *appear* to be insensate. Even patients under general anesthesia — a deeper

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[12] *See* Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678 (1992); Nathan Chernoy et al., *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. of Palliative Care 31-38 (1994) (describing practice of terminal sedation).

state of sedation — often feel and hear.[13] Hence, terminal sedation may serve only to make the death less excruciating to observers. Certainly, allowing physicians to administer coma-inducing medications and to monitor patients in that state until dehydration or starvation eventually causes death cannot be reconciled with the AMA's ethical concerns and the action/omission distinction suggested by a number of the State's amici.

The Ninth Circuit is correct that the aspect of liberty invoked here follows naturally from this Court's prior decisions. 79 F.3d at 813-14; Pet. App. A-56 to A-58. Moreover, reposing end-of-life decisions with the dying patient is essential to ensure that the government not be empowered either to deny the option of a hastened death or to compel one. *See* Brief of Respondents in No. 95-1858. If the power to determine whether to continue a pregnancy rested with the state, for example, the state could compel abortion as well as deny it. So, too, if the power to decide how a life should end is vested in the state, the state might determine that, since death is inevitable, no purpose is served by honoring a futile choice to suffer through a few more days of life.

B. The Liberty to Direct the Withdrawal of Medical Treatment to Hasten Death Is No Different Than That in Choosing to Hasten Impending Death With Medications Prescribed For That Purpose

Of all the Court's decisions with respect to personal liberty, perhaps the closest to the present case factually is *Cru-*

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[13] *See generally* R. Cork et al., *Is There Implicit Memory After Propofol Sedation?*, 76 Brit. J. Anaesthesia 492 (1996); N. Moerman et al., *Awareness and Recall During General Anesthesia*, 79 Anesthesiology 454 (1993).

zan. There the Court acknowledged that competent, dying persons have the right to direct the removal of life-sustaining medical treatment and thus hasten death. 497 U.S. at 278; *see* Brief for the United States as Amicus Curiae Supporting Petitioners at 13-14. The Court recognized that the liberty to make this end-of-life decision is uniquely and "deeply personal." 497 U.S. at 281; *see id.* at 289 (O'Connor, J., concurring). The Court in *Cruzan* addressed the question of the level of evidence Missouri could require as to the wishes of a presently incompetent person that life-sustaining treatment be withdrawn. The Court made it clear that a state's interest in this area is limited to ensuring a voluntary decision — in safeguarding personal autonomy but not in interfering with it. *Id.* at 281.

The dissenting opinions differed as to the limitations that the State could impose to ensure voluntariness, but agreed with the majority as to the personal nature of end-of-life decisions and the limited state interest in such decisions:

> Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

Id. at 310-12 (Brennan, J., with Marshall & Blackmun, JJ., dissenting).

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental." . . .

> The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.

Id. at 343 (Stevens, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

Dr. Roe, Mr. Doe, and Mr. Poe were indisputably competent, and their requests were indisputably voluntary. Respondents do not challenge procedures such as those in *Cruzan* that seek to assure rather than deny free will. The Court's acknowledgment in *Cruzan* of the profoundly personal and protected nature of the decision to die through refusal of medical treatment squarely supports recognizing that aspect of liberty claimed here. *See Compassion*, 79 F.3d at 824; Pet. App. A-82. The Solicitor General agrees. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 13-14.

The patient's decision in *Cruzan* had not been made contemporaneously with the circumstances that triggered the potential effectuation of the decision, and it had not been memorialized in any manner, giving rise to significant questions regarding the patient's true wishes with regard to maintenance of life support. Whatever had been the case at one time, there was no way to determine if it was still Nancy Cruzan's wish to die. Because of her comatose condition, she would not have known if her wishes had been ignored. In contrast, the patient-plaintiffs here were available to have their competence and voluntariness tested, were capable of retracting their decisions, and had made their decisions clear. Nonetheless, the State required Dr. Roe, Mr. Doe, and Mr. Poe to continue to suffer excruciating pain, anxiety, and loss of

dignity and to know that those who cared for them were compelled to reject their requests for help or face prosecution.

From the patient's perspective, the decision to direct the withdrawal of a feeding tube or a respirator, or to submit to terminal sedation, is no different than the decision to choose to hasten death by consuming drugs prescribed for this purpose. In each situation, patients request such assistance for the same reason: they want to exercise what control they can over when and how they die. In each situation, plaintiffs make the decisions based upon their own values, in consultation with their own doctor and, if they wish, their own families.

Similarly, from the doctor's perspective, honoring the patient's decision to direct the withdrawal of treatment or to submit to terminal sedation is assisting in a patient's wish to die. The recognized right to direct the withdrawal of treatment requires medical assistance in, for example, removing a feeding tube or ventilator and in administering medications to ease pain, the sensation of suffocation, and anxiety while that is done. Such assistance requires far more physician action than the assistance sought in this case, as acknowledged by the Solicitor General. Brief for the United States as Amicus Curiae Supporting Petitioners in No. 95-1858 at 12. The provision of terminal sedation requires affirmative and continuing medical assistance in initiating the coma through the administration of medication and maintaining it until starvation or dehydration causes death.[14] Paul Rousseau, *Terminal*

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[14] Some of the State's amici assert that the kind of physician assistance sought by the patient-plaintiffs would be unethical. Such beliefs did not deter the Court from recognizing a constitutionally protected right in *Roe v. Wade*. And they did not halt recognition of the right to direct the withdrawal of life support. *Colyer*, 660 P.2d at 744 ("It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on

Sedation in the Care of Dying Patients, 156 Archives of Internal Med. 1785 (1996).

Thus, the constitutional principle behind recognizing the patient's liberty to direct the withdrawal of artificial life support applies at least as strongly to the choice to hasten impending death by consuming lethal medication. The District Court and the Ninth Circuit in this case, as well as the Second Circuit in *Quill*, found that no relevant distinction could be drawn between the decision to direct the withdrawal of life-sustaining medical treatment and the decision of a mentally competent, terminally ill adult to consume medications prescribed for the purpose of hastening death. *Compassion*, 79 F.3d at 821-24; Pet. App. A-75 to A-82; 850 F. Supp. at 1467; Pet. App. E-27 to E-28; *Quill*, 80 F.3d at 727. From the patient's or the doctor's perspective, it is exactly the same choice, and the record here establishes that medical assistance in hastening death is necessary to permit implementation of that choice for persons not on life support. JA 35, 49, 55-56, 73, 190.

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the patient."). Moreover, where studies have been conducted, a majority of physicians already view physician assistance in the case of mentally competent, terminally ill patients as ethical. *See, e.g.*, Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994); Melinda A. Lee, *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 New Eng. J. Med. 310 (1996). Legalizing the practice, bringing it into the open, and imposing protection for the patient can only increase the integrity of the practice and of the profession. *See, e.g.*, Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119, 120 (1994); Brief Amici Curiae of Bioethics Professors Supporting Respondents; Brief Amicus Curiae of American College of Legal Medicine. Physicians who do not wish to honor a patient's request can refer the patient to another doctor. *See Smith v. Cote*, 513 A.2d 341, 355 (N.H. 1986) (Souter, J., concurring); Wash. Rev. Code § 70.122.060(4).

The alternatives to physician assistance involve violent means — almost unimaginable for a competent person and leaving a horrible last impression on family members — or an uncertain and often botched attempt with poison or drugs not prescribed for this purpose.[15] Dr. Glucksberg's patient was forced to jump from a bridge; Dr. Halperin's to suffocate herself. The undisputed record shows that terminally ill persons who seek to hasten death need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a doctor can provide.[16] *See* JA 190. Attempts to hasten death without such advice frequently fail, often leaving the patient in worse shape than before, or succeed only after terrible pain and suffering.[17] *Id.*

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[15] The violent death by self-inflicted gunshot of Nobel Physics Laureate Percy Bridgman, in the final stages of cancer, exemplifies the brutality of this option. Professor Bridgman's last message: "It is not decent for Society to make a man do this to himself. Probably, this is the last day I will be able to do it myself." Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* 152-53 (1993); *see* Brief Amici Curiae of Surviving Family Members in Support of Respondents.

[16] Patients often choose not to use such a prescription. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 922 (1996). Knowing that they control how much suffering they must endure reduces the patients' anxiety and helps avoid premature violent deaths such as that of Professor Bridgman.

[17] *See* Russel D. Ogden, *Euthanasia, Assisted Suicide & AIDS* (1994); JA 190 (emotional and psychological effect of inability to obtain assistance can be devastating to terminal patients who feel abandoned by their physicians when most in need of their help); Brief Amici Curiae of Surviving Family Members in Support of Respondents; Clyde H. Farnsworth, *Bungled AIDS Suicides Often Increase the Suffering*, N.Y. Times, June 14, 1994, at B9.

C. The Challenged Statute Does Not Serve Legitimate State Interests; State Regulation Would Better Protect Any Such Interests

The liberty here is as substantial and fundamental as that recognized in *Casey*, *Cruzan*, and Wash. Rev. Code § 70.122.010. As discussed in the Brief of Respondents in No. 95-1858, however, the Court need not categorize this aspect of liberty, or determine which system of categorization, if any, is appropriate. The prohibition must fail under the venerable strict scrutiny standard, the undue burden model employed in *Casey*, or the rational relationship test. The statute simply does not serve the interests asserted by the State of Washington. *See* Brief Amici Curiae of Law Professors in Support of Respondents.

The three interests identified by the State are: (1) protecting terminally ill patients against being extinguished by third parties against their will because their lives are viewed as having little quality; (2) protecting patients against physician errors in judgment as to mental competence and terminal illness; and (3) protecting the State's right to choose whether or not to legalize this practice. Brief for the Petitioners at 33-36, 47-49. As discussed in detail below, none of these interests is sufficient to justify the total prohibition of individual liberty in these circumstances, and none is served by this statute.

The challenged statute absolutely forbids physician assistance, even where, as here, the patient's voluntariness of choice, mental competence, and terminal state are undisputed. The statute is not an effort to discourage, to inform, or to regulate. *See Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 446-47 (1983) (state may require provision of accurate medical information to abortion patient); *Maher v. Roe*, 432 U.S. 464, 474 (1977) (state may express preference against abortion); *Roe*, 410 U.S. at 150 (state may regulate to

ensure safety of abortion). Wash. Rev. Code § 9A.36.060 is a flat prohibition, and it does not serve the supposed ends argued by the State. "[L]iberty may not be interfered with, under the guise of protecting the public interest, by legislative action which is arbitrary or without reasonable relation to some purpose within the competency of the state to effect." *Meyer v. Nebraska*, 262 U.S. 390, 399-400 (1923).[18]

Indeed, when one compares the statute to the asserted state purposes, it is clear that there is so little "fit" that either the statute is irrational or it serves some other, unstated and undefended purpose. *See Romer v. Evans*, 134 L. Ed. 2d 855, 865-66, 868 (1996). The statute is grossly overinclusive; it interferes with the liberty of even those who are clearly competent and uncoerced. It is equally underinclusive; it does not prohibit the same decision, with the same fatal consequences, for those on life support or those who would submit to a medically induced coma and starvation.[19] The statute allows

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[18] Some amici refer to adverse implications for survivors. The Washington Supreme Court has held that this interest does not exist unless family members object to the patient's action. *Colyer*, 660 P.2d at 743. Moreover, the act of a mentally competent, terminally ill adult to hasten impending death is nothing like the typical suicide, as shown by the State's legalization of assisted death through withdrawal of life support. Indeed, it is undisputed on the record that by recognizing the choice to hasten death with drugs prescribed for that purpose, death will be nonviolent and humane, easing a tortured dying process. The inevitable mourning can proceed with the comfort of knowing a loved one's wishes regarding this most personal and profound matter were respected and that the patient suffered less. *See* JA 74-75; *Compassion*, 79 F.3d at 827; Pet. App. A-90; Brief Amici Curiae of Surviving Family Members in Support of Respondents.

[19] The State has done little to protect against abuse in the context of withdrawal of life support. *E.g.*, Wash. Rev. Code § 70.122.020(8) and .030(2) (no second opinion required as to terminal condition). Reason-

withdrawal of life support even though patients on life support, due to its extended cost, are more likely to be pressured to hasten death. The statute does not serve the mentally ill or weak-willed as effectively as would tailored regulation. The current prohibition leaves those individuals vulnerable to the unrestrained "back alley" practitioner, rather than careful, open, peer-reviewed opinions by doctors currently unwilling to risk a crime prosecution. The legitimate purposes that the State advances in support of the law can be accomplished through regulation that would not unduly burden liberty, and the State must legislate within that framework.

This case involves state interests of less weight than those at stake in *Casey*. In upholding the right of women to choose, the Court in *Casey* recognized that abortion is an "act fraught with consequences for others" and raises numerous potentially conflicting interests, particularly that of the separate, silent life of the fetus. 505 U.S. at 871. It is the state interest in fetal life that makes the abortion cases so difficult. This case directly involves no life apart from that of the individual making the personal choice.

1. The Challenged Statute Is Not Necessary to Protect Against Third-Party Usurpation of the Patient's Control Over the Remaining Days of Life

The State of Washington has no interest in mandating that the lives of the terminally ill be extended as long as possible. Indeed, the State disavows any such interest in recognizing a terminally ill patient's right to direct withdrawal of life support. Wash. Rev. Code § 70.122.051. Thus, as the Ninth Circuit noted, the State has accepted the notion that its interest in preserving life should ordinarily give way, in the case of a competent, terminally ill adult, to the wishes of the patient. 79 F.3d at 817; Pet. App. A-65. The existing exception to the challenged statute acknowledges that denial of assistance in dying extinguishes the only liberty a terminally ill person has left. *Id.* at 820; Pet. App. A-72; *see Quill*, 80 F.3d at 729. For a patient at death's door, the choice is not between continuing life and bringing on death but between a painful and degrading death or a humane and dignified one.

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able regulation of both categories of patients would better honor both the Constitution and the asserted state interests.

As was noted in a case accepted by the Washington Supreme Court with respect to the interests of the State in the lives of the terminally ill: "[T]he individual's right to privacy grows as . . . the prognosis dims." *In re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976), *discussed in Colyer*, 660 P.2d at 743.

Recognition of a dying patient's liberty to choose how to die would in no way suggest that physicians may kill those patients who do not request assistance in dying. The State has a strong interest in protecting against usurpation of the dying patient's wishes by others. To say that the State must respect the individual's autonomy does not imply that the State must stand by should others try to override that autonomy and extinguish that life. The legalization of a patient's right to direct withdrawal of life support did not increase the risk of such patients to involuntary euthanasia or other forms of murder, much less legalize such conduct. The State retains an undiminished interest in ensuring that the lives of such patients, however short, are protected against extinction against their will by third parties. The value of life is cheapened not by allowing a humane death but by denying a competent human being the right of choice.

2. Ensuring That Assistance Is Provided Only to Mentally Competent, Uncoerced, Terminally Ill Patients Better Protects the State's Interests Than Does the Current Covert Practice

(a) Prohibiting All Competent, Uncoerced, Terminally Ill Patients From Exercising a Right to Protect a Few Incompetent or Coerced Patients From Erroneously Exercising That Right Does Not Serve Any State Interest

The State's interest in preventing suicide by those with mental illness or susceptible to "undue influence" is premised on assuring free choice. As with refusal of life-sustaining treatment, an interest in free choice is not furthered by denying choice to those who are mentally competent and exercising free will.[20] "If the state's interest in preventing suicide is really an interest in preventing irrational suicides, coerced suicides, or suicides by the young, then the state has little interest, if any, in preventing informed, competent, terminally ill individuals who are free from undue influence from committing suicide." Mark Strasser, *Assisted Suicide and the Competent Terminally Ill*, 74 Or. L. Rev. 539, 558 (1995); *see Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (state's interest in the

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[20] Various of the State's amici contend that no dying patient desiring to hasten death could be free of mental illness. This factual contention contradicts the undisputed record of this case. JA 22-31. Even the New York State Task Force ("Report"), relied upon heavily by petitioners and amici, refutes this "myth." Report at 16. The Task Force reports that depression is the exception in the terminally ill and can be diagnosed. *Id.* at 13, 26; *see* Brief Amici Curiae of Mental Health Professionals in Support of Respondents.

prevention of irrational self-destruction is not at issue in competent, rational decision to refuse medical treatment when death is impending) (cited with approval on this point by the Washington Supreme Court in *Colyer*, 660 P.2d at 743).

The patient-plaintiffs did not suffer from mental illness and were acting of their own free will. JA 25, 28, 31. It is uncontroverted that the patients whose claims are asserted through the physician-plaintiffs are mentally competent, and that physicians can determine who is competent. JA 35, 49, 55, 73; *Compassion*, 850 F. Supp. at 1458; Pet. App. E-8. The present case is limited to those who seek a humane, hastened death not because they are troubled, disturbed, misled, confused, unduly influenced, or in need of psychiatric care, but rather because they are dying and suffering unbearably in the process. The Ninth Circuit recognized that the liberty extends only to such patients. 79 F.3d at 793, 834, 837; Pet. App. A-9 to A-10, A-106, A-113 to A-114. This Court drew the same dividing line in *Cruzan*. 497 U.S. at 279. The State remains free to protect those not facing death and to enact procedures to protect those who are terminally ill to ensure that their end-of-life decision is informed and voluntary. The State certainly remains free to prosecute those who "knowingly cause . . . another person to attempt suicide."

The State of Washington has previously convinced this Court that doctors can determine if someone is suffering from a mental disorder and that review by two doctors is adequate to assure accuracy. *Washington v. Harper*, 494 U.S. at 222, 232 (1990). In that case, the Court also agreed with the State that it would not assume that doctors would abuse their power. *Id.* at 222 & n.8. Moreover, the right claimed in the present case is access to life-ending medication that the patient may self-administer if the patient so chooses, providing an additional assurance of volition.

The State and some of its amici contend that it would not be permissible to limit the right at issue to the mentally competent. This Court accepted that boundary without question in *Cruzan*, 497 U.S. at 277-79, 287 n.2. The right at issue is by definition a very personal one that involves a conscious decision by the individual. A right of self-determination would never justify, and is in fact antithetical to, involuntary euthanasia. The State's interest in protecting incompetent individuals is undisputed and of great weight. The state protects the incompetent in matters ranging from contracts to criminal trials; there has been no "slippery slope" from allowing competent citizens to exercise those rights to allowing incompetent citizens to do so. *E.g.*, *Faretta v. California*, 422 U.S. 806, 833-35 (1975) ("the inestimable worth of free choice" belongs to competent citizens exercising "informed free will").

Finally, some of the State's amici urge that shortcomings in the health care system are so coercive as to justify a prohibition on choice. This supposed state interest has never been espoused by the State and would justify the governmental prohibition of any patient choice that might be influenced by limited finances and care options. Free will under our Constitution is not limited only to easy decisions in uncomplicated circumstances. The solution to this concern is to fix the risks in the health care system, not to trample individual liberty. *See, e.g.*, Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204 (prohibiting premature discharge from hospital after childbirth).

(b) Terminal Illness Is a Workable Boundary

The State suggests, and some of the State's amici contend, that it is difficult in some cases to determine when a patient has reached the terminal phase. Of course, no one knew for sure that Nancy Cruzan would not have regained consciousness. *See* 497 U.S. at 266-67 ("virtually no chance"). In fact, since 1979 Washington has used the terminal dividing line for this purpose with respect to life support and does not even require a second opinion, Wash. Rev. Code § 70.122.020(8)-(9), and most other states and the federal government define and use "terminal" for a variety of state functions, including authority to direct the withdrawal of life support.[21] This Court need not define terminal as an initial matter; that can be left to the states. The important point is that terminal can be defined. Whatever might have been the case in 1854, the record of this case shows that, for many patients, physicians now can determine terminal stage with assurance.[22] The State did not dispute the record below that the physician-plaintiffs and other doctors can determine when many illnesses have progressed to this stage.[23]

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[21] *E.g.*, Cal. Health & Safety Code § 7186(j); 42 U.S.C. 1395x(dd)(3)(A).

[22] The medical profession also utilizes the terminal diagnosis as a clinical bright line in provision of terminal sedation. *See* Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Med. 1785, 1785 (1996) ("prior to initiation of sedation, clinicians must ascertain the need for sedating therapy, including the presence of a terminal disease with impending death").

[23] There is no right for those patients who are not terminally ill and not imminently facing death. The State has a real interest in preserving the lives of those who can still contribute to society and have the potential to enjoy life again. As explained in the Brief of Respondents in No. 95-1858, the right of patients to direct the withdrawal of life support with the intent to bring about their own deaths is limited to the terminally ill or those in a permanent vegetative state. In Washington, both statutory and common law are so limited. Other states have created exceptions for patients who refuse treatment for religious reasons. If, as some of the State's amici argue, there are states that, regardless of religious considerations, allow refusal of temporary life support for conscious patients who are not terminally ill, but simply wish to die, that

The claimed state interest can support an absolute prohibition as to all patients only if the rights of those where accurate diagnosis is possible must be sacrificed to avoid any risk of physician error.[24] As discussed in the Brief of Respondents in No. 95-1858, this sort of sacrifice has never been permitted under our Constitution. As with all human endeavors, diagnosis of terminal illness is not infallible, but that does not justify a total prohibition on the right to choose a humane, hastened death. As the Court noted in *Casey*, in dealing with the question of fetal viability:

> [T]here is no line other than viability which is more workable. To be sure, as we have said, there may be some medical developments that affect the precise point of viability, . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter.

505 U.S. at 870.

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is not a right guaranteed by the Constitution and is instead one created, wisely or unwisely, by such states. Protecting the constitutional right at stake here will not alter the wisdom of those states. Contrary to the assertions of the State's amici, there has been no slide down the slippery slope in the Netherlands, where the practice of assistance in dying, though still illegal, is conducted more openly. *See Special Reports from the Netherlands*, 335 New Eng. J. Med. 1676, 1699, 1706 (1996); *Quill*, 80 F.3d at 730-31; *Compassion*, 79 F.3d at 830 n.114; Brief Amici Curiae of Bioethics Professors Supporting Respondents.

[24] If error occurs, it is generally in the direction of excessive optimism regarding remaining life expectancy. *See, e.g.*, Lorna E. Forster & Joanne Lynn, *Predicting Life-Span for Applicants to Inpatient Hospice*, 148 Archives of Internal Med. 2540 (1988); David B. Reuben et al., *Clinical Symptoms and Length of Survival in Patients With Terminal Cancer*, 148 Archives of Internal Med. 1586 (1988).

The line drawn by the Ninth Circuit is reasoned and workable and serves the rule that "[l]iberty must not be extinguished for want of a line that is clear." *Id.* at 869. "Constitutional rights do not always have easily ascertainable boundaries." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 771 (1986). Certainly the doctor should inform the patient of the risks of misdiagnosis, but that does not justify prohibiting informed patient choice.

The primary concern of the State's amici appears to be that the possibility of an erroneous diagnosis means that no line separates the terminally ill from others, so that the "slippery slope" toward assisted suicide on demand will be unavoidable. To the contrary, erroneous placement of a person on the wrong side of a bright line does not mean that the line does not exist, nor does it constitute an endorsement of suicide on demand by the healthy. If such an error were to occur, it would be because a mentally competent person, based upon medical advice (after whatever reasonable safeguards regarding such advice the State wished to impose), made the voluntary choice to end suffering. An error of this sort would not open the door to euthanasia.

If rights could be denied for fear that they might be exercised unwisely or upon inaccurate information, they would not be rights at all. Numerous rights can be exercised upon inaccurate information: marrying, voting, having an abortion, and even refusing medical treatment. "[I]t is far better to permit some individuals to make incorrect decisions than to deny all individuals the right to make decisions that have a profound effect upon their destiny." *Id.* at 781-82 (Stevens, J., concurring).

Finally, some of the State's amici contend that the Ninth Circuit has stripped elderly, chronically ill, or disabled persons of the State's protection. Nothing in the Ninth Circuit's deci-

sion supports this. All such persons are fully entitled to protection against coercion and other abuse, and all are, if competent, as entitled to a humane death as anyone else when they reach the final stages of dying. *See* Brief Amici Curiae of GMHC, LAMBDA, and Prominent Americans with Disabilities in Support of Respondents.

(c) The Random, Covert, and Unregulated Practice Under the Existing Prohibition Poses Greater Risk to the State's Interests

Entirely absent from the State's brief is any mention of the well-established fact that, notwithstanding the criminal prohibition, physicians frequently provide assistance in dying to patients.[25] This reflects the demand of such patients for their liberty, and the respect of many doctors for its exercise. This assistance currently is provided in a covert manner without oversight. No safeguards ensure that the patient's decision is informed and voluntary. No other professionals are involved to ensure that the patient is indeed in the terminal phase of illness, is mentally competent, and has had the benefit of

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[25] *See, e.g.*, Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919 (1996) (in year preceding study, 12 percent of physicians had been asked to provide assistance in hastening death, and 24 percent of patients making such requests received assistance); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119, 120 (1994) ("relatively widespread secret practice of physician-assisted death in the United States, which is completely unregulated"); Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, Boston Globe, Feb. 28, 1992, at 5; Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients, A Second Look*, 320 New Eng. J. Med. 844 (1989); Sherwin B. Nuland, *How We Die: Reflections on Life's Final Chapter* 153 (1993) ("a muted practice that has existed since Aesculapius was in swaddling clothes").

palliative care. Only affluent and educated consumers of medical services are likely to have access to a willing, competent physician, in much the same way as those with financial and educational means could obtain abortions prior to *Roe*.[26] Patients without access to a willing, competent provider must abandon their rights or seek a "back alley" provider who may be a careless, unqualified charlatan.[27] The State cannot reconcile this situation with its asserted interest.

3. Federalism Does Not Justify Unlimited Government Power at the Expense of Individual Autonomy

The State's argument before the Court is almost entirely premised upon federalism — contending that state governments, rather than competent, dying citizens, are empowered under the Constitution to decide how such citizens should die.

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[26] Because clandestine assistance is available to the powerful, the notion that the political process can be expected to protect all citizens in this context, Brief for the United States as Amicus Curiae Supporting Petitioners at 11-12, is as factually flawed as it is legally irrelevant. Moreover, our culture is one of denial where mortality is concerned. Death is generally taboo. Kathy Charmaz, *The Social Reality of Death* 67, 83-87 (1980); William E. Phipps, *Death: Confronting the Reality* 55-56 (1987); Philippe Aries, *The Hour of Our Death* 569-571 (1981); Louise Harmon, *Fragments on the Deathwatch*, 77 Minn. L. Rev. 1, 105-18 (1992). Citizens do not deal with mortality until directly confronted with imminent death. *See* Ernest Becker, *The Denial of Death* (1973). The constituency that would bring about political change is composed of ailing, dying persons who cannot direct their waning energy to political action.

[27] *See* Mark Strasser, *Assisted Suicide and the Competent Terminally Ill*, 74 Or. L. Rev. 539, 604 (1995) ("it may be that individuals like Kevorkian are able to break laws precisely because of society's failure to offer legal procedures by which people can achieve a painless, dignified death") (footnote omitted).

This argument is contradicted by the Fourteenth Amendment's explicit restructuring of federalism, by the Ninth Amendment's rule for interpreting the Fourteenth Amendment, and by the Court's decisions interpreting both.

The State argues primarily that the decision is "a complex and controversial issue" that should be left to state legislatures.[28] *E.g.*, Brief for the Petitioners at 9. The State contends not so much that exercise of this right would compromise its substantive interests, but that recognizing the citizen's right to choose would deny the State's right to choose.

Constitutional liberty belongs to individuals, not states, however, and the question of whether liberty must give way to supposed state objectives cannot be left totally to the states. "[T]his Court too has its responsibility." *Rochin v. California*, 342 U.S. at 168-69. Thus, the State's citation to *Casey* for the proposition that "it is conventional constitutional doctrine that where reasonable people can disagree the government can adopt one position or the other," Brief for the Petitioners at 38, does not advance its position. The very next sentence in *Casey* recognizes that "[t]hat theorem, however, assumes a state of affairs in which the choice does not intrude upon a protected liberty." 505 U.S. at 851; *see* Brief Amici Curiae of State Legislators in Support of Respondents.

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[28] The State's invocation of Justice Brandeis's laboratory of social policy experimentation is misplaced. *See* Brief for the Petitioners at 48. The ruling below invites "dialogue with legislators" and leaves appropriate room for the political process to operate. Ruth B. Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1204-05 (1992). Striking down the flat prohibition of the exercise of liberty of mentally competent, terminally ill patients leaves the states free to regulate exercise of that liberty.

Moreover, the State must assert more than an abstract religious or philosophical disagreement; the statute must serve a legitimate public purpose. It would directly contradict the most basic, anti-authoritarian premise of the constitutional guarantee of liberty to permit specific exercises of rights to be subordinated to the controversial, moral dictates of a majority or powerful minority. Indeed, it has long been recognized that, where the democratic process impinges on constitutional rights, "the judiciary then has a duty to intervene in the democratic process." *Schweiker v. Wilson*, 450 U.S. 221, 230 (1981). The Constitution protects citizens against moral and political domination by the state, especially with regard to freedoms of conscience and control over one's destiny. *See Wooley v. Maynard*, 430 U.S. 705 (1977); *West Virginia Bd. of Educ. v. Barnette*, 319 U.S. 624, 636-37, 642 (1943).

In any event, affirmance of the decision below works no improper judicial encroachment into the state legislative domain. The Court in *Casey* permitted states to enact rules governing previability abortion so long as these do not impose an undue burden on the woman's ability to make her decision. 505 U.S. at 872-79. The Court in *Cruzan* expressed great deference to a state's procedural effort to assure competence and voluntariness. 497 U.S. at 280-82. Thus, the Ninth Circuit properly recognized that the State can adequately regulate to protect its legitimate interests here as well.[29] 79 F.3d at 816, 833, 837; Pet. App. A-63, A-104, A-112.

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[29] It is not "improper legislating" for a court to note that simple regulatory protections (waiting period, information on alternatives, second opinion) would safeguard any legitimate interests. Model regulations incorporating these and other safeguards have been proposed. *See, e.g.*, Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Brief Amici Curiae of State Legislators in Support of Respondents (describing various legislative proposals). Many of the interests raised by the State's amici have not been asserted by the

II. SECTION 9A.36.060 DENIES EQUAL PROTECTION TO COMPETENT, TERMINALLY ILL ADULTS WHO ARE NOT ON LIFE SUPPORT

The Ninth Circuit did not reach the question whether Section 9A.36.060 denies equal protection, 79 F.3d at 838; Pet. App. A-115, although it could discern no "ethical or constitutionally cognizable" basis upon which to distinguish between physician assistance by prescribing life-ending medication and the act of withdrawing life support. *Id.* at 821-24; Pet. App. A-75 to A-82. The question was fully briefed and argued below and offers an alternative basis upon which this Court can and should affirm the judgment. *Washington v. Confederated Bands & Tribes of Yakima Indian Nation*, 439 U.S. 463, 476 n.20 (1979). Equal protection did form the basis of the Second Circuit's judgment in *Quill*. 80 F.3d at 727. To avoid duplication of the full briefing submitted in No. 95-1858, the discussion here focuses on the specifics of Washington statutory and case law.

Even before *Cruzan*, the Washington Supreme Court recognized the right of a competent, terminally ill adult to hasten death by directing that life-sustaining medical treatment be suspended. *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987). The Washington court effectively excluded from the facial coverage of Section 9A.36.060 those who assist in such decisions.

The Washington Natural Death Act, though limited to withdrawal of life-sustaining treatment, explicitly recognizes the same "fundamental right" in "individual autonomy" as

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State itself and could be voiced and, subject to undue burden analysis, properly addressed in the legislative process.

that at stake here. Wash. Rev. Code § 70.122.010. "The legislature . . . finds that . . . such prolongation of the process of dying for persons with a terminal condition . . . may cause loss of patient dignity, and unnecessary pain and suffering . . . ." *Id.* "The legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own health care . . . ." *Id.* The State recognized "the dignity and privacy which patients have a right to expect." *Id.*

These interests and rights apply equally to all mentally competent, terminally ill adults. The statute specifically allows those terminally ill adults who are on life-sustaining treatment to direct their doctors to withdraw such treatment, Section 70.122.030, and it protects such doctors from civil and criminal liability without specifically mentioning Section 9A.36.060. Wash. Rev. Code § 70.122.051. The statute also provides that it "shall not be construed as providing the exclusive means by which individuals may make decisions regarding their health treatment, . . . nor limiting the means provided by case law more expansive than [the statute]." Wash. Rev. Code § 70.122.910.

The State does not dispute that Washington law recognizes a fundamental liberty interest or that it then distinguishes between those competent, terminally ill adults whose condition requires life-sustaining treatment and those whose condition does not. The first group has the right to direct the course of treatment with the specific purpose and result of hastening death. The second group does not, and must suffer the very same pain and suffering and loss of dignity and privacy from which the statute and common law protect the first group.

Under the current arbitrary and irrational scheme imposed by the State of Washington, patients on life support may choose death, even if they are not suffering, and despite any

risk of error of misdiagnosis of condition or competency. Terminally ill patients not on life support are prohibited from surrendering the few days or weeks they have left, even if they must endure them in extreme and unrelenting pain and suffering. The State has never provided any justification for this discrimination — not on the face of the statute, not in the legislative history, and not even as a matter of litigative hindsight.

The State's argument, that the common law right to be free from bodily invasion applies only to the first group, is refuted by the State's admission that the common law was only one of the "underpinnings" for protecting the first group's liberty. Brief for the Petitioners at 43-44. The State does not deny that the other underpinnings, liberty and self-determination, were more important, as is apparent from the express legislative findings in Wash. Rev. Code § 70.122.010. Furthermore, the case upon which the State relies as to the common law in Washington, *Colyer*, not only recognized the liberty of "an adult who is incurably and terminally ill" under both the federal and state constitutions, but held that such a right "*encompasses* the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests." 660 P.2d at 742 (emphasis supplied). Only later in its opinion did the court turn to the "common law right to be free from bodily invasion [as] an alternative basis." *Id.* at 743. Thus, the right in Washington is not limited to the refusal of treatment, and the purpose is not just in avoiding battery. The purpose, as here, is avoiding futile, painful, and degrading prolongation of the dying process.

The State's other argument in support of this arbitrary distinction is purely circular. The State says that "one who intentionally acts to cause or contribute to another's death, is with rare exceptions, guilty of criminal conduct." Brief for the Petitioners at 44. Honoring the liberty and the wish to die of a competent, terminally ill patient by withdrawing life support is

one of those rare exceptions. As the Washington Supreme Court held in *Colyer*, the challenged statute does not apply to "the exercise of a constitutional right." 660 P.2d at 751. The question is how honoring in a slightly different fashion the same liberty and same wish of another competent, terminally ill patient is any different. The State has no answer.

The State cites to various state court decisions holding that directing the withdrawal of life support is not suicide and that assisting the patient in removing life support is not assisted suicide. Brief for the Petitioners at 37. Proving that Washington and other states make a distinction does not prove that the distinction is justified. That these courts felt a compulsion to create an exception to their assisted suicide statutes for physician withdrawal of life-sustaining technology confirms traditional respect for patient autonomy, especially at the end of life, but it hardly means that the legislatures that enacted the statutes subscribed to any purposes that would distinguish between dying patients. The act of a dying, suffering patient choosing to shorten the period of suffering before death by consuming life-ending medication is no more suicide in the traditional or typical sense than is withdrawal of life support. In both, the only question is the manner, not the fact, of taking action to hasten death when death is impending. Continuation of life is not a choice for these patients.

Some of the State's amici contend that the discriminatory treatment is justified by the difference between an act and an omission. Withdrawal of life support, they say, is somehow not an act, though it requires activity. Terminal sedation does not cause death, they believe, though it requires the administration of medication to induce and maintain sedation until death inevitably occurs. The State certainly would not adopt this distinction, and apply it in this way, if, for example, a hired killer removed a respirator or induced a coma and cut off nutrition and hydration. Is the State itself immune if its jailers "omit" to feed prisoners, and they die? In fact, the

writing of a prescription is less active than the removal of a gastrostomy tube. *Quill*, 80 F.3d at 729. If this distinction were the critical factor, the right to direct withdrawal of life support would not be limited to terminally ill patients. The action/inaction distinction, rejected by Justice Scalia in *Cruzan*, 497 U.S. at 296-97, exists only in the minds of those who wish to *preserve the appearance* that they are not participating in hastening death. *Compassion*, 79 F.3d at 821-22; Pet. App. A-75 to A-78. This basis cannot support such discrimination.

Nor is a distinction found in the fact that a patient on life support might feel a "captive" of that type of care. *See* Brief for the Petitioners at 42 (citing *Cruzan*, 497 U.S. at 288). As discussed in the Brief of Respondents in No. 95-1858, a dying, suffering patient, whose life and dying process have been extended by modern medical technology, but who is not presently on life support, similarly becomes a captive of her disintegrating body and the medical care that brought her to that juncture. *See* Brief Amici Curiae of Bioethics Professors Supporting Respondents. This patient has the identical motivation and objective as the patient whose condition happens to encompass life-sustaining technology: the desire to hasten impending death in a humane and dignified manner.

Thus, as properly recognized by the District Court in this case, which did reach the equal protection claim, the decision to request termination of life-sustaining treatment to hasten death is different in no material respect for a terminally ill patient from requesting life-ending drugs. *Compassion*, 850 F. Supp. at 1461, 1466-67; Pet. App. E-15, E-25 to E-28. The same conclusion was reached by the Second Circuit in *Quill*. 80 F.3d at 729.

Having recognized a liberty — indeed, a "fundamental" liberty — in determining whether to endure a prolonged dying process, the State may not deny it to one group of patients,

particularly where regulation can achieve any legitimate state interests, interests that apply equally to both groups. The Court should affirm the judgment below because the statute impermissibly burdens liberty and denies equal protection.

CONCLUSION

The Court has long recognized that the constitutional right of liberty stands as a barrier against laws that deny individuals the right to make the most fundamental choices affecting their values, their bodies, and the course of their lives. The Constitution protects the liberty of a dying citizen to choose how to die in accordance with her own intensely personal convictions. The private values that inform this decision are too central to personality, too much at the core of liberty, to allow the State to decide how everyone must act or what everyone must believe.

The Ninth Circuit correctly applied the Court's precedent in finding that the Fourteenth Amendment protects the liberty of competent, terminally ill citizens to determine their moment of death and to do so in a manner that comports with values formed over their lifetime, while at the same time recognizing the legislative role in crafting safeguards to protect legitimate state interests. Respondents urge the Court to remain true to principled application of precedent and once again define the freedom guaranteed by the Constitution's own promise, the promise of liberty, and affirm the judgment below.

The Court should also, or alternatively, affirm on the ground that the challenged law violates the Equal Protection Clause. Having recognized a liberty to choose to die in a dignified manner with limited pain and suffering, the State may not preclude some individuals from exercising that liberty.

Respectfully submitted,

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IN THE
SUPREME COURT
OF THE
UNITED STATES

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners/Defendants,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents/Plaintiffs.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

REPLY BRIEF FOR PETITIONERS

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I. WASHINGTON'S ASSISTED SUICIDE STATUTE DOES NOT VIOLATE DUE PROCESS

This case involves a challenge to Wash. Rev. Code 9A.36.060, a statute adopted in 1975 as a recodification of pre-existing statutes dating back to the first Territorial Legislature. Br. Pet'rs at 4-6; App. Pet. Cert. at G-1 to G-3.

The precise legal issues in this case are whether there is a constitutionally protected liberty interest under the Due Process Clause in committing suicide that includes assistance in so doing; and, if so, whether the statute is nonetheless constitutional because it advances legitimate state interests.[1]

The Due Process Clause of the Fourteenth Amendment protects, *inter alia*, "life, liberty, or property" against state deprivation. This case involves two of those components—life and liberty. The outcome of the case will determine whether a State must value the liberty claims of a few when those claims conflict with a State's goal of protecting the lives of *all* its people.

A. Respondents Disregard The Court's Well-Established Analytical Approach To Substantive Due Process

The issue arises under "the substantive component of the [Due Process] Clause that protects individual liberty

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[1] Respondents proffer the Equal Protection Clause as an alternative theory to support the decision below. Br. Resp'ts at 42-47. Petitioners have previously demonstrated that Washington law does not violate the Equal Protection Clause. Pet. Writ Cert. at 22-26; Br. Pet'rs at 41-44. *See also Vacco* Br. Pet'rs at 9-19; *Vacco* Br. Amici Curiae States Supp. Pet'rs; *Vacco* United States Amicus Curiae Supp. Pet'rs. Accordingly, Petitioners focus this brief on the Due Process arguments advanced by Respondents and their amici.

against 'certain government actions regardless of the fairness of the procedures used to implement them.'" *Collins v. Harker Heights*, 503 U.S. 115, 125 (1992) (quoting *Daniels v. Williams*, 474 U.S. 327, 331 (1986)).

This Court has developed certain enduring principles as "guideposts for responsible decisionmaking" in the "unchartered area" (*id.*) of substantive due process analysis.

The "analysis must begin with a careful description of the asserted right, for 'the doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.'" *Reno v. Flores*, 507 U.S. 292, 302 (1993) (quoting *Collins*, 503 U.S. at 125).

The Court then determines whether the asserted liberty claim is "implicit in the concept of ordered liberty" (*Palko v. Connecticut*, 302 U.S. 319, 325 (1937)) or "deeply rooted in this Nation's history and tradition" (*Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.)). Reliance on the Nation's history and tradition provides an objective framework within which to make the ultimately subjective determination as to whether a particular activity is, or is not, a component of the liberty protected by the Due Process Clause.

The Court's careful and consistent application of these principles serves "to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government." *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986). Expressed another way, "[a]ppropriate limits on substantive due process come not from drawing arbitrary lines but rather from careful 'respect for the teachings of history and solid recognition of the basic values that underlie our society.'" *Moore*, 431 U.S. at 503 (quoting *Griswold*

v. Connecticut, 381 U.S. 479, 501 (1965) (Harlan, J., concurring)).

Respondents' approach to the threshold question—whether there is a constitutionally protected liberty interest at all—ignores the Court's established analytical approach. Rather, they assert:

> "The proper question is whether society, and the Court's constitutional interpretation, has afforded individuals the right to make personal decisions regarding their bodies, medical care, and life-course without burdensome government intrusion." Br. Resp'ts at 17-18.[2]

Respondents pose the wrong question. The question is not whether some activities involving personal decisions affecting bodily integrity *have* been accorded constitutional protection. Rather, the issue in this case is whether the decision to commit suicide, and having assistance in carrying out that decision, *is to be* protected by the Constitution. The answer to this question is plainly no.

Neither Respondents nor their New York counterparts make any effort to demonstrate that the asserted right to assisted suicide is "deeply rooted in our Nation's history and tradition" (*Moore*, 431 U.S. at 503) or "implicit in the concept of ordered liberty," (*Palko*, 302 U.S. at 325) having presumably concluded, for good reason, that any such enterprise would fail.[3] "Nor can it be said that the

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[2] Respondents do not attempt to defend the Ninth Circuit's broadly phrased recognition of a liberty interest in "determining the time and manner of one's death." App. Pet. Cert. at A-27.

[3] Respondents rely on the ineffective effort of the Ninth Circuit to find historical support for the notion of a right to commit suicide, asserting that "the historical record is checkered." Br. Resp'ts at

right to assisted suicide claimed by [Respondents] is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true." *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir. 1996), *cert. granted sub nom, Vacco v. Quill*, Case No. 19-1858. *See* Br. Pet'rs at 21-25. *See generally* Br. Amicus Curiae State Legis. Supp. Pet'rs.[4]

Respondents' liberty interest argument rests on their expansive view of the Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). *Casey* followed two decades of multiple, contentious challenges to the Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), which held that previously recognized constitutional protections accorded to procreation included the right of a woman to obtain an abortion. The *Casey* Court declined to overrule *Roe*, concluding instead that "the essential holding of *Roe v. Wade* should be retained and once again reaffirmed." *Casey*, 505 U.S. at 846.

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18 n.9. Their New York counterparts completely ignore the history and tradition prong of this Court's jurisprudential approach. See generally *Vacco* Br. Resp'ts. The ACLU repeats—but does not improve upon—the Ninth Circuit's historical analysis. *See* Br. Amici Curiae Supp. Resp'ts of ACLU at 4-7.

[4] The Court's reliance on the history and tradition of our country does not reflect an "historically frozen concept of constitutionally protected liberty." Br. Nat'l Women's Health Network Amici Curiae Supp. Resp'ts at 10 n.11. Rather, it provides the means whereby the Court can assure that its jurisprudence

> "represent[s] the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. . . . having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke." Poe v. Ullman, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting).

The *Casey* Court's one hundred ten page explanation of its decision included a paragraph in which the Court summarized its prior decisions affording constitutional protection to "marriage, procreation, contraception, family relationships, child rearing, and education." *Casey*, 505 U.S. at 851. The last three sentences of that paragraph describe common elements of the particular activities addressed in those previous cases:

> "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.*

In effect, Respondents argue that these last three sentences from *Casey* stand for the proposition that *all* "intimate and personal choices a person may make in a lifetime" (*id.*) are constitutionally protected. According to Respondents' logic, a decision to end one's life is "intimate and personal"—therefore, such a decision is, like the abortion decision at issue in *Casey*, constitutionally protected.

Respondents misread *Casey*. The language from *Casey* on which Respondents rely is *descriptive*, not *prescriptive*. It *describes* certain specific actions to which constitutional protection had previously been accorded. It does not purport to *prescribe* that any activity falling within the grammatical construct of the passage necessarily

qualifies for enhanced protection under the "liberty" component of the Due Process Clause.[5]

Respondents' view of the *Casey* decision is that the passage quoted above represents a new formulation of the test for identifying liberty interests entitled to heightened protection under the Due Process Clause. Under Respondents' view, *Casey* represents a wholesale departure from the Court's prior due process jurisprudence. The traditional test—whether a particular claim to liberty is "deeply rooted in this Nation's history and tradition" (*Moore*, 431 U.S. at 503) or "implicit in the concept of ordered liberty" (*Palko*, 302 U.S. at 325)—no longer applies. Rather, according to Respondents, liberty interests after *Casey* are defined as those matters "involving the most intimate and personal choices a person may make in a lifetime [including] choices central to personal dignity and autonomy." *Casey*, 503 U.S. at 851.

Under Respondents' view, not only did the *Casey* opinion jettison the Court's test for determining the existence of a constitutionally protected liberty interest, it also cast doubt on the continued viability of several of the Court's prior decisions. *See, for example, Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 (1973) (rejecting a claim of constitutional protection to conduct on the basis that it involved only consenting adults). The Court in *Slaton* catalogued other cases where the Court had upheld statutes

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[5] Respondents' analysis under *Casey* is based on a flawed syllogism, along the following lines: Apples, oranges, and grapefruit are fruits. They are round in shape and edible. A cabbage is also round in shape and edible; therefore, a cabbage must be a fruit as well. A choice to commit suicide, though "intimate and personal," is of a fundamentally different nature than the choice to marry, to have a child (or not), to live with one's grandchildren, or to send them to a private school. *See* Br. Pet'rs at 25-28.

regulating conduct arguably included within the scope of the language from *Casey* quoted above, and noted that "[t]he state statute books are replete with constitutionally unchallenged laws against prostitution, *suicide*, voluntary self-mutilation, brutalizing 'bare fist' prize fights, and duels." *Id.* at 68-69 n.15 (emphasis added).[6]

Indeed, even the *Roe* Court's rejection of the proposition "that one has an unlimited right to do with one's body as one pleases" (*Roe*, 410 U.S. at 154) is subject to revisitation if, indeed, Respondents' expansive view of the *Casey* decision is correct.

Respondents' view of *Casey* is *not* correct. *Casey* was grounded in the principles of the Court's prior jurisprudence—relied on in *Roe*—which recognized that decisions about procreation are "implicit in the concept of ordered liberty" (*Palko*, 302 U.S. at 325) and thus protected under the Due Process Clause.[7] The *Casey* decision was bolstered by principles of *stare decisis*, the application of which serve to strengthen "the Court's capacity to exercise the judicial power and to function as the Supreme Court of a Nation dedicated to the rule of law." *Casey*, 505 U.S. at 865, *and see generally* 864-69; *see also* Br. Pet'rs at 31-33.

By arguing that this Court should abandon the use of the Nation's history and tradition and the concept of ordered liberty as the primary "guideposts for responsible

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[6] At the time this opinion was written, no State criminalized attempted suicide; therefore, the reference to "suicide" must have been to assisted suicide statutes such as that at issue here.

[7] *Roe* also concluded that prior to laws adopted in the latter half of the 19th century, largely to protect women's health, women generally had access to an abortion, especially early in pregnancy. *Roe*, 410 U.S. at 140-41. Thus, its decision protecting a woman's access to an abortion was not contrary to the Nation's history and tradition.

decisionmaking" (*Collins*, 503 U.S. at 125) in the due process arena, Respondents acknowledge that the decision below can only be affirmed if in fact the *Casey* decision represents a wholesale rejection of the Court's prior analytical approach rather than a principled reaffirmation of "the essential holding of *Roe v. Wade*" (*Casey*, 505 U.S. at 846). *See* Br. Resp'ts at 11-22; *Vacco* Br. Resp'ts at 19-28; *see also* Br. Amici State Leg. Supp. Resp'ts at 4-6.

Indeed, Respondents' New York counterparts assert that failure to affirm the decision below on the basis of *Casey* "would render this Court's decision in *Casey* itself vulnerable to repudiation as unprincipled and *ad hoc*, an illegitimate interference with the power of the State." *Vacco* Br. Resp'ts at 24 n.10. This is exactly wrong. The *Casey* decision, though controversial, was grounded in this Court's traditional jurisprudential approach and demonstrated that the *Roe* decision was the outgrowth of the constitutional protection to decisions about contraception and procreation. To suggest, as the New York Respondents do, that *Casey*'s credibility rises or falls with the instant case does a disservice to the authors of the *Casey* opinion by suggesting its constitutional analysis cannot stand on its own.

B. Respondents' Liberty Interest Argument Is Unprincipled And Illogical

Three other aspects of Respondents' liberty interest argument merit mention.

First, Respondents and their New York counterparts claim that the interest they seek to enshrine as a constitutional right is limited: "The *present* case is limited to those who seek a humane, hastened death . . . because they are dying *and* suffering unbearably in the process." Br. Resp'ts at 33 (emphasis added). *See also Vacco* Br. Resp'ts at 21 ("the only right asserted by the patient-plaintiffs and claimed before this Court is the right of the

competent, terminally ill patient to choose whether to endure a death marked by intolerable agony, degradation, and suffering").[8]

Yet the doctrinal support they offer for this asserted right does not supply the limits they claim.[9] For example, Respondents argue that "[t]he decision how to die is the final life-shaping decision a person can make." Br. Resp'ts at 17. Does not this statement apply with equal force to *anyone* who commits suicide, not just the terminally ill? As the panel opinion below noted:

> "The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also

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[8] It is doubtful, of course, that the "right," if it exists, can be so limited as Respondents suggest. *See* Br. Pet'rs at 44-47; Br. Am. Geriatrics Soc'y Amicus Curiae [Supp. Pet'rs] at 15-27.

[9] In the same vein, the Solicitor General suggests the existence of a liberty interest with no doctrinal limitation to the terminally ill. Relying on cases involving the procedural protections of the Due Process Clause, he asserts that the substantive component protects a liberty interest in "avoiding severe pain or suffering." Br. United States Amicus Curiae Supp. Pet'rs at 14. This assertion misses the mark in two ways. A requirement of procedural protection under the Due Process Clause does not equate to the special protection accorded certain fundamental liberty interests under the substantive component of the Clause. Moreover, "[t]he question presented . . . is not whether a person has a constitutional right . . . not to suffer. Rather, the question . . . is whether the constitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance." *People v. Kevorkian*, 447 Mich. 436, 476 n.47, 527 N.W.2d 714, 730 n.47 (1994), *cert. denied*, 115 S. Ct. 1785 (1995). Petitioners agree with the ultimate conclusion advanced by the United States that the Washington statute does not violate the Due Process Clause. However, the constitutional analysis utilized in arriving at a particular conclusion is often as important as the conclusion itself.

expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is the uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult." App. Pet. Cert. at D-12; *see also* Br. Am. Suicide Found. Amicus Curiae [Supp. Pet'rs] at 5-12.[10]

Respondents' argument for a right that belongs to some but not all—"[t]here is no right for those patients who are not terminally ill and not imminently facing death" (Br. Resp'ts at 35 n.23)—belies any claim that the asserted right to assisted suicide is "implicit in the concept of ordered liberty." *Palko*, 302 U.S. at 325.

Second, although Respondents and their amici argue for a right to assisted suicide for mentally competent, terminally ill patients, their amici, like the court below, at the same time recognize that "State laws or regulations governing physician-assisted suicide are *both necessary and desirable* to ensure against errors and abuse, and to protect legitimate state interests." App. Pet. Cert. A-102 (emphasis added). *See, e.g.*, Br. Amici ACLU (urging "support [for] the use of legislative safeguards"); *Vacco* Br. Resp'ts at 3 ("Close regulation is required for many of the reasons put forward by petitioners and their *amici*."); Br. Amici Curiae of Coun. for Secular Humanism Supp. Resp'ts at 14 ("[N]o

[10] Similarly, Respondents' Equal Protection arguments are not doctrinally limited to the terminally ill. The right to refuse medical treatment belongs to everyone. Respondents' arguments that assisted suicide is no different than refusing medical treatment are no more persuasive in the due process context than they are in the equal protection concept.

responsible proponent of legalized assisted suicide maintains that the practice should not be subject to *stringent* regulation." (emphasis added)).[11]

The apparent consensus among the proponents of the asserted right, that it must be carefully controlled to limit its exercise by the public at large, is strong evidence that it has no nexus to the concept of "liberty" as that term is understood in common parlance or as reflected in this Court's Due Process Clause jurisprudence.

What other liberty interest granted constitutional protection by this Court has carried with it a recommendation by its advocates that the exercise of the claimed liberty must be (1) limited to only a few people and (2) closely regulated to avoid its abuse? The answer, of course, is none. One can only imagine the hue and outcry that would arise—and rightfully so—should the suggestion be advanced that the nature of other constitutionally protected liberty interests—marriage, procreation, family relationships, pre-viability abortions—*requires* that they be carefully regulated, lest the right be abused. *See also* Br. Am. Med. Ass'n Amici Curiae Supp. Pet'rs at 25-26; Br. Bioethics Professors Amicus Curiae Supp. Pet'rs at 23-26.

Finally, it is just not true, as Respondents and their New York counterparts claim, that affirming the decision below is "essential to ensure that the government not be empowered either to deny the option of a hastened death or to compel one." Br. Resp'ts at 22; *see also Vacco* Br.

[11] Of course, these concerns are well-justified. *See* Br. Dist. Atty. Milwaukee Cy. Amicus Curiae Supp. Pet'rs (arguing that creating a constitutionally mandated exemption from States' homicide laws for physician-assisted suicide "will cause grave practical difficulties in the enforcement of our homicide laws" (at 2) and cateloguing (at 12-16, and in the appendix) examples of "intrafamily and other homicides" (at 12) where the decision below is problematic to law enforcement).

Resp'ts at 29-30. This argument is based on the *Casey* Court's recognition that failure to recognize a *liberty* interest in the abortion context could lead to a situation where "the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it." *Casey*, 505 U.S. at 859.

Unlike the abortion context, in which the liberty protection is a "two-way street" (*Vacco* Br. Resp'ts at 30), any purported action by a State to "compel" an early death for those for whom Respondents advocate would run afoul of the State's duty, also under the Fourteenth Amendment, to protect *life*.[12]

The *Roe* opinion made clear that the decision to abort a nonviable fetus does not implicate the life of a person: "[A]n abortion is not 'the termination of life entitled to Fourteenth Amendment protection.'" *Casey*, 505 U.S. at 913 (Stevens, J., concurring in part and dissenting in part) (quoting *Roe*, 410 U.S. at 159). Had the contrary been true, the *Roe* Court noted, "the [argument for a right to abortion] collapses, for the fetus' right to life is then guaranteed specifically by the [Fourteenth] Amendment." *Roe*, 410 U.S. at 156-57.

It is inarguable that assisted suicide *does* involve the taking of *life* entitled to Fourteenth Amendment protection. Declining to recognize a liberty interest in assisted suicide would not leave the terminally ill—or anyone else—exposed to a risk of State-compelled death.[13]

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[12] *See* Br. Amicus Curiae States Supp. Pet'rs at 10-13 (arguing that recognizing a "liberty" interest to take a life is contrary to the language and design of the Due Process Clause).

[13] On the other hand, recognizing a liberty interest in assisted suicide may indeed create a "one-way street" in the wrong direction by implying that some lives are entitled to lesser protection than others. *See* Br. Nat'l Spinal Cord Injury Ass'n Amicus Curiae Supp. [Pet'rs] at 1-3, 17-36; Br. Amici Curiae Nat'l Legal Ctr. for Medically Dependent & Disabled Supp. Pet'rs at 12-24.

C. Washington's Statute Furthers Important State Interests

Even if the Court finds the existence of a constitutionally protected liberty interest, that does not end the inquiry. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 279 (1990). Rather, the Court must then decide whether the statute nonetheless prevails over whatever liberty interest may be involved, because it furthers legitimate State interests. *Id.*

The Court has identified two tests by which statutes not implicating abortion rights are measured.[14] At a threshold level, the statute must rationally advance legitimate State interests. *Reno*, 507 U.S. at 301-03. If a statute burdens a fundamental liberty interest, it must be "narrowly tailored to serve a compelling state interest." *Id.* at 302.[15]

The Respondents and their amici acknowledge the existence of important State interests:

- "The State has a *strong* interest in protecting against usurpation of the dying patient's wishes by others. . . . The State retains an *undiminished*

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[14] Statutes regulating abortion rights are judged by the undue burden standard announced in *Casey*: "An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey*, 505 U.S. at 878. This test has not been applied outside of the abortion context.

[15] Not even Respondents contend that the subjective "sliding scale" balancing test performed by the Ninth Circuit below was correct.

interest in ensuring that the lives of such patients, however short, are protected against extinction against their will by third parties." Br. Resp'ts at 31 (emphasis added).

- "The State's interest in protecting incompetent individuals is . . . of *great weight.*" *Id.* at 34 (emphasis added).
- "Undoubtedly the protection of people who might seek to end life mistakenly or under pressure is a *compelling* interest." *Vacco* Br. Resp'ts at 37 (emphasis added).

The Court has previously acknowledged the important role that statutes such as that at issue here serve in furthering the States' interest in protecting the lives of its citizens:

> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280.

Respondents assert that the statute at issue does not meet either applicable test, arguing that it is both "overinclusive" and "underinclusive," and that, in their judgment, a regulatory approach in which physician-assisted suicide is allowed to some but not to all would "better protect" these State interests. *See generally* Br. Resp'ts at 28-39. Yet neither Respondents nor their *amici* deny that *any* attempt to legalize assisted suicide would inevitably lead

to at least some persons dying either prematurely or involuntarily, or both.[16]

The reality of human mortality is that there is a continuum of circumstances under which we perish. *See* Br. Am. Geriatrics Soc'y at 4-11. Respondents describe tragic individual stories that are close to the line that now separates "*letting* the patient die [from] *making* the patient die." S. Carter, *The Culture of Disbelief* 236 (1993) (emphasis in original). Respondents appear to hope that these terrible stories will evoke an emotional reaction that will lead this Court to mandate moving that line.

But Respondents do not offer a workable stopping point along the continuum where a new line can be established—in effect, their argument provides the "slippery slope." If refusing medical care equals assisted suicide for the terminally ill, why not for the chronically ill or the just plain unhappy, who have the same right to refuse treatment? If assisted suicide is equivalent to health care, can allowing a guardian to consent to one and not the other pass the equal protection test Respondents suggest? While there may indeed be individual circumstances that are not well-served by the current line, a State legislature could reasonably—and rationally—conclude that "there is no line other than [that

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[16] *See, e.g.*, Br. Resp'ts at 36 ("diagnosis of terminal illness is not infallible"); Br. Amici ACLU at 20 (asserting that safeguards would reduce the "likelihood of misdiagnosis to a very small order of probability," an error rate that it presumably believes is acceptable); Br. Amicus Curiae Julien M. Whitaker, M.D., Supp. Resp'ts at 22 ("There can be no doubt that from time to time certain individuals possessed of malicious intent (whether family members, friends, or physicians) will exert an untoward influence on the terminally ill, urging them to make a decision for or against physician-assisted suicide that may not be the one the patient would make if fully possessed of independent reason.").

drawn by current law] that works better." *Casey*, 505 U.S. at 870.

In short, Respondents contend that the State is required to adopt a policy that sacrifices the lives of at least some of its citizens in order to accommodate the interests of those for whom they advocate. A military commander preparing for battle must accept the inevitability of casualties and develop battle plans designed to keep them to an "acceptable" level. State legislatures, when crafting public policy, should not be constitutionally required to engage in the same calculus.

The compelling nature of the State's interest in protecting the lives of its citizens, combined with the profound impact on at least some of those citizens should Respondents' arguments prevail, demonstrate that the Washington statute passes constitutional muster regardless of which test the Court applies.

D. Respondents Oversimplify The Complexity Of The Task Before The Court

Respondents assert that "[t]he present case is limited to those who seek a humane, hastened death . . . because they are dying and suffering unbearably in the process." Br. Resp'ts at 33. While the "present case" may be limited as Respondents suggest,[17] there is no doubt that recognition of a liberty interest in physician-assisted suicide sufficient to invalidate the Washington statute will generate several more rounds of litigation challenging whatever limits or procedures a State may craft. It is not difficult to imagine

[17] The Ninth Circuit did not see the case as necessarily limited to the mentally competent (App. Pet. Cert. at A-101 n.120), to assisted suicide (as opposed to voluntary euthanasia) (*id.* at A-100), or, for that matter, to physicians (*id.* at A-116 n.140).

this Court being asked to rule on the constitutionality of at least the following:

- whether a particular State's definition of "terminal illness" is too restrictive;
- whether a State's requirement for two, or three, "or an entire committee of physicians" (Br. Amici ACLU at 20 n.30) to verify the patient's condition is too onerous;
- whether a State's standard of determining mental competence unduly limits access to assisted suicide;
- a State's requirement that mental competence be evaluated by a psychiatrist or psychologist;[18]
- a State's requirement for a waiting period between an initial request for physician-assisted suicide and the provision of assistance;[19]
- a State's procedural requirement for consultation with family members;[20]

[18] The Brief Of The Washington State Psychological Association, et al., Amici Curiae In Support Of Respondents, at page 24 note 9, notes such a limitation under the recently approved Oregon Measure 16 and argues that "other mental health professionals, including social workers and professional counselors [with appropriate training] would also be capable of performing such evaluations."

[19] *Cf. Casey*, 505 U.S. at 885-87 (upholding a Pennsylvania twenty-four hour waiting period for obtaining an abortion); *see* Or. Rev. Stat. § 127.840 (requiring two oral requests at least fifteen days apart for life-ending medication before it can be provided); *see also* Br. Amici Curiae Gary Lee, M.D., Supp. Pet'rs at 17 (criticizing the fifteen-day period of the Oregon statute as too narrow).

[20] The guidelines developed by Compassion in Dying, a plaintiff below, specify that "[a]ssistance with suicide will not be provided if there is expressed disapproval by members of the immediate

- a State's requirement that the medication be self-administered;[21]
- whether the limitations suggested by the Respondents—terminal illness, mental competence, even adulthood—are themselves constitutionally defensible.

Respondents suggest that States are able to answer these questions "as an initial matter" (Br. Resp'ts at 35) and "subject to undue burden analysis" (Br. Resp'ts at 42 n.29). That may be true, but it is also inarguable that the final answer to these and other myriad issues raised by the decision below will have to come from this Court, should the statute at issue be struck down as Respondents and their amici argue it should be.

II. THE WASHINGTON STATUTE REFLECTS THE IMPORTANT VALUE OUR SOCIETY PLACES ON PROTECTING AND PRESERVING LIFE

This case, and the issues surrounding it, present no easy answers. In the final analysis, the fulcrum of decision on the issue of physician-assisted suicide is a value judgment between respecting the autonomy of some versus protecting the lives of all. The historic, and current, judgment

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family." J.A. at 13-14. The court below noted that "a similar requirement by the state would raise constitutional concerns." App. Pet. Cert. at A-90 n.100.

[21] *See Vacco* Br. Resp'ts at 40 n.20 ("any competent individual, however disabled, who is able . . . to *communicate* a voluntary decision to receive life-ending medication could certainly be enabled, through modern technology, to *self-administer* it" (emphasis in original)). *But see* Br. Amici Curiae Gay Men's Health Clinic Supp. Resp'ts at 19 n.9 (acknowledging that some patients would require "the assistance of [their] physician[s] in administering the drug").

reflected in the statute at issue here values the lives of those whom the statute protects over the autonomy of those whose suicides the statute prevents.

Whether that value judgment has changed or should change is a topic of discussion and debate throughout the land. *See* Br. Pet'rs at 9-16. Unless foreshortened by a pre-emptive decision from this Court, this debate will no doubt continue.

As the New York Task Force concluded, a decision in favor of allowing physician-assisted suicide, even in limited form, will do more than change the law. It will change our society.

> "The prohibition against assisted suicide and euthanasia carries intense symbolic and practical significance. While suicide is no longer prohibited or penalized, the ban against assisted suicide and euthanasia shores up the notion of limits in human relationships. It reflects the gravity with which we view the decision to take one's own life or the life of another, and our reluctance to encourage or promote these decisions.
>
> "If assisted suicide and euthanasia are legalized, it will reflect changed attitudes about the practices. Just as significant, it will prompt further change. Social attitudes will evolve in part because our laws convey acceptance and sanction. More far reaching will be the shift in attitude as assisted suicide or direct killing become more frequent and more widely practiced. If the practices become a standard part of the arsenal of medical treatments, it would profoundly affect our response to those cases that are sanctioned and to those that are not. The momentous nature of the actions, and the sense of caution or gravity with which they are pursued,

would naturally lessen for both health care professionals and for the public. By legalizing the practices, we will blunt our moral sensibilities and perceptions." New York State Task Force Report at 131-32.

Such a change in our national attitude about issues of life and death—if there is to be one at all—should manifest itself in the first instance through changes in the laws of the States; it should not be forced upon the Nation through judicial fiat.

III. CONCLUSION

The decision of the United States Circuit Court of Appeals for the Ninth Circuit should be reversed, and the matter remanded with direction to grant summary judgment to the Petitioners.

Respectfully submitted this 27th day of December, 1996.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

WASHINGTON, ET AL., PETITIONERS

v.

HAROLD GLUCKSBERG, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether a state statute that makes it unlawful to aid a person to attempt suicide violates the Due Process Clause insofar as it prohibits a physician from prescribing lethal doses of medication for use by competent, terminally ill persons who request the medication for the purpose of ending their lives.

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INTEREST OF THE UNITED STATES

This case raises the question whether a State may prohibit a physician from prescribing lethal dosages of medication for competent, terminally ill adults who request such medication for the purpose of ending their lives. In holding that the State does not have a sufficient interest to justify such a prohibition, the court of appeals relied on the fact that the State permits terminally ill adults to refuse life-sustaining treatment. Pet. App. A82.

The United States owns and operates numerous health care facilities which permit patients to refuse life-sustaining treatment, but do not permit physicians to assist patients in committing suicide by providing lethal dosages of medication. The Department of Veterans Affairs (VA),

which operates 173 medical centers, 126 nursing homes, and 55 in-patient hospices, has a policy manual that generally permits the withholding and withdrawal of life-sustaining medical treatment in response to a patient's request. In contrast, the manual forbids "the active hastening of the moment of death." Department of Veterans Affairs, Manual M-2, ¶ 31.08(c) (Nov. 1991). Similarly, the VA's hospice program guide states that "[t]he hospice philosophy does not condone nor participate in any action intended to hasten * * * the patient's death." Department of Veteran Affairs, Veterans Health Admin., Program Guide 1140.10: Hospice Program ¶ 1.02(b) (Sept. 1996). The military services, which operate 124 medical centers, the Indian Health Service, which operates 43 hospitals, and the National Institutes of Health, which operate a clinical center, follow a similar practice which is not embodied in writing.

In addition, Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388-115, requires all health care providers receiving Medicaid or Medicare, first, to inform all competent adults about state laws concerning the right of patients to refuse life-sustaining treatment and, second, to record any advance directives the patient might have. 42 U.S.C. 1395cc(f). No federal law, however, either authorizes or accommodates physician assisted suicide. The United States therefore has a substantial interest in the resolution of the question presented in this case.

STATEMENT

1. Under Washington law, a person is guilty of a criminal offense "when he knowingly causes or aids another person to attempt suicide." Wash. Rev. Code § 9A.36.060(1) (1994). A violation of that prohibition constitutes a felony punishable by imprisonment for as long as five years and a fine of up to $10,000. *Id.* §§ 9A.36.060(2), 9A.20.020(1)(c).

Four physicians who treat terminally ill patients, three terminally ill persons (all of whom have since died), and an organization that provides assistance to terminally ill persons filed suit in the United States District Court for the Western District of Washington against the State of Washington and its Attorney General challenging the State's prohibition against assisted suicide. Pet. App. A10. In their complaint, plaintiffs alleged that "[t]he Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." *Id.* at A17 n.7. Plaintiffs sought a declaration that the prohibition against assisted suicide violates the Due Process Clause to the extent that it interferes with the exercise of that asserted right. *Id.* at A17-A18. Plaintiffs also sought a declaration that the Washington statute violates the Equal Protection Clause insofar as it draws a distinction between terminally ill patients who seek lethal doses of medication and terminally ill patients who refuse life-sustaining treatment. *Id.* at A18.

At the time of the filing of the complaint, each of the patient plaintiffs was mentally competent and terminally ill, each was experiencing severe pain or suffering, and each had made a voluntary decision to hasten his or her death by seeking lethal doses of medication. Pet. App. E3-E4. Jane Roe, a doctor, was suffering from cancer that had metastasized throughout her body; she was bedridden; she experienced constant pain which became especially sharp and severe when she moved; medication could not fully alleviate her pain; and she suffered from swollen legs, bed sores, poor appetite, nausea, vomiting, impaired vision,

incontinence of bowel, and general weakness. *Id.* at E3. John Doe, an artist, was dying of AIDS; he had already suffered twice from pneumonia; he had severe skin and sinus infections; he suffered from grand mal seizures and extreme fatigue; and he was destined to lose all of his vision. *Id.* at E3-E4. James Poe, a retired sales representative, suffered from emphysema; his condition caused him a constant sensation of suffocating; he was connected to an oxygen tank at all times; he regularly took morphine to calm the panic reaction associated with his feeling of suffocation; and he suffered from severe leg pain. *Id.* at E4. Based on their professional judgments, the four physician plaintiffs all believe that they should prescribe life-ending medication for competent, terminally ill patients who request such medication for the purpose of hastening their deaths. *Id.* at E7. They have been deterred from doing so, however, by the statutory prohibition against assisted suicide. *Ibid.*

On cross-motions for summary judgment, the district court ruled in plaintiffs' favor. Pet. App. E1-E29. The court held that the prohibition against assisted suicide unduly burdens the Fourteenth Amendment right of competent, terminally ill persons to hasten their deaths. *Id.* at E28-E29. The court also held that the prohibition violates the Equal Protection Clause insofar as it distinguishes between terminally ill patients who seek to end their lives through lethal doses of medication and terminally ill patients who seek to end their lives by refusing life-sustaining treatment. *Id.* at E29.

2. a. A divided court of appeals panel reversed. Pet. App. D1-D27. Judge Noonan, joined by Judge O'Scannlain, concluded that the prohibition against assisted suicide does not violate either the Due Process Clause or the Equal Protection Clause. *Id.* at D11-D20. The majority concluded that there is no liberty interest in obtaining

assistance for suicide, that the prohibition against assisted suicide is justified by several legitimate state interests, including the State's interest in preserving life, and that the distinction between assisted suicide and the refusal of life-sustaining treatment is not irrational. *Ibid.* Judge Wright dissented. *Id.* at D20-D27.

b. On rehearing en banc, the court of appeals affirmed the district court's judgment. Pet. App. A1-A164. By an 8-3 vote, the court of appeals held that the prohibition against assisted suicide violates the Due Process Clause of the Fourteenth Amendment "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths." *Id.* at A19-A20.

The court began its analysis by holding that there is a constitutionally protected "liberty interest in choosing the time and manner of one's death." Pet. App. A21. The court drew that conclusion primarily from this Court's decision in *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992). The court of appeals specifically relied on the statement in *Casey* that "matters[] involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Id.* at 851. The court of appeals reasoned that "[l]ike the decision of whether or not to have an abortion, the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity and autonomy.'" Pet. App. A57. The court therefore concluded that "[a] competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent." *Ibid.*

The court of appeals also viewed *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), as persuasive authority for its conclusion that there is a liberty interest in determining the timing of one's death. Pet. App. A62. "[B]y recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water," the court of appeals concluded, *Cruzan* "necessarily recognizes a liberty interest in hastening one's own death." *Ibid.*

Having found a protected liberty interest, the court proceeded to "a balancing test under which * * * the individual's liberty interests [are weighed] against the relevant state interests." Pet. App. A22. After assessing the interests asserted by the State, the court concluded that they do not justify a blanket prohibition against prescribing life-ending medication for use by competent, terminally ill patients. *Id.* at A63-A114.

The court concluded that, although preserving life "is one of the [S]tate's important functions," that interest "is dramatically diminished if the person [the State] seeks to protect is terminally ill * * * and has expressed a wish that he be permitted to die." Pet. App. A72. The court acknowledged that the State has "a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated." *Id.* at A73. The court concluded, however, that the State's interest in preventing such occurrences is diminished in the case of terminally ill patients who wish to die, because "the decision to commit suicide [by such persons] is not senseless, and death does not come too early." *Id.* at A74. Finally, while the court acknowledged that the State has an "important" interest in preventing decisions to end life that result from "undue * * * influence[]" by family

members and physicians, *id.* at A84, the court concluded the State should address that "real" concern through procedural safeguards, rather than through a complete ban on assisted suicide, *id.* at A86-A89, A102-A103. The court concluded that "[b]y adopting appropriate, reasonable, and properly drawn safeguards Washington could ensure that people who choose to have their doctors prescribe lethal doses of medication are truly competent and meet all the requisite standards." *Id.* at A103.

Judge Beezer filed a dissenting opinion. Pet. App. A118-A160. He concluded that mentally competent, terminally ill adults have "an autonomy-based, nonfundamental liberty interest in committing physician-assisted suicide," *id.* at A139, and that the relevant inquiry is therefore whether the State's prohibition against assisted suicide "rationally advances some legitimate governmental purpose," *id.* at A155. Judge Beezer concluded that the Washington statute satisfies that standard because it "rationally advances four legitimate governmental purposes: preserving life, protecting the interests of innocent third parties, preventing suicide and maintaining the ethical integrity of the medical profession." *Id.* at A119. Judges Fernandez and Kleinfeld joined Judge Beezer's opinion, and each also wrote a separate opinion. *Id.* at A160-A164. Judge Fernandez expressed the view that "no one has an even nonfundamental *constitutional right*" to commit suicide. *Id.* at A160. Judge Kleinfeld saw no need "to decide whether suicide is a constitutionally protected right" because Washington "has a rational basis for preventing assisted suicide." *Id.* at A162.

c. The full Ninth Circuit was polled, but declined to rehear the case. Pet. App. C1-C2. Three judges dissented from the order rejecting the request for rehearing en banc by the full court. *Id.* at C2-C26.

SUMMARY OF ARGUMENT

The State's prohibition against assisted suicide does not violate the Due Process Clause.

A. A competent, terminally ill adult has a constitutionally cognizable liberty interest in avoiding the kind of suffering experienced by the plaintiffs in this case. That liberty interest encompasses an interest in avoiding not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily or mental functions in the terminal stage of an illness.

This Court's cases make clear that, when the State itself inflicts severe pain or suffering on someone, a liberty interest is implicated. *Ingraham* v. *Wright*, 430 U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A similar liberty interest is implicated when severe pain or suffering is caused by an illness, but the State compels a person to remain in that condition by prohibiting access to medication that would relieve that pain or suffering. See *Planned Parenthood* v. *Casey*, 505 U.S. 833, 852 (1992).

Although *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990), involves a liberty interest of greater magnitude, it supports the conclusion that a liberty interest is at stake in this case. *Cruzan* holds that the core liberty interest in avoiding medical treatment through bodily invasions is implicated even when the treatment is life-sustaining and its withdrawal would likely lead to a person's death. 497 U.S. at 279. By a parity of reasoning, the liberty interest at issue here is still implicated at the point at which avoiding severe pain or suffering and ending life coalesce.

While there is a liberty interest at stake in this case, the court of appeals erred when it equated the right to

choose an abortion with that interest. The right to choose an abortion implicates a constellation of liberty and equality rights of fundamental importance that are not implicated here.

B. Overriding state interests justify the State's decision to ban physicians from prescribing lethal medication. The State has an interest of the highest order in prohibiting its physicians from assisting in the purposeful taking of another person's life. The view that there should be an exception to the State's general policy of protecting life for cases in which a competent, terminally ill adult voluntarily requests life-ending medication strikes a responsive chord in many people. At this point in history, however, a State could responsibly conclude that creating such an exception would endanger persons who are not competent to seek lethal medication, persons whose decision to seek lethal medication is not truly voluntary, or those persons who are not in fact terminally ill. The difficulty that physicians have in determining whether requests for assisted suicide come from patients with treatable pain or depression, the vulnerability of terminally ill patients to subtle influences from physicians, family members, and others, and the continuing possibility that someone can be misdiagnosed as terminally ill all support a State's decision to ban all assisted suicides.

The State's interest is not lessened by the fact that the State permits competent, terminally ill adults to refuse life-saving medical treatment. There is an important and common-sense distinction between withdrawing artificial supports so that a disease will progress to its inevitable end, and providing chemicals to be used to kill someone. The imposition of life-saving medical treatment, which often involves highly invasive equipment and procedures, is also a more serious interference with personal liberty. In addition, the risks involved in honoring a person's re-

quest to refuse treatment are far less extensive than the dangers involved in permitting physicians to prescribe lethal medication. Thus, while there is a constitutional right to refuse treatment that the State cannot override, there is no corresponding constitutional right to obtain access to lethal medication.

The difficulty that the State would have drawing any line that is more reasonable than the current line reinforces that conclusion. Once a State decides to create an exception to its prohibition against assisted suicide, there is no obvious stopping point.

State legislatures undoubtedly have the authority to create the kind of exception to assisted suicide fashioned by the court of appeals. But there is no constitutional basis for imposing that exception on all the States. Because terminal illness potentially affects all Americans—all races, both genders, and every income group—there is every reason to believe that state legislatures will address the urgent issues involved in this case in a fair and impartial way.

ARGUMENT

THE STATE'S PROHIBITION AGAINST ASSISTED SUICIDE DOES NOT VIOLATE THE DUE PROCESS CLAUSE

This case requires the Court to determine the scope of the protection afforded by the Due Process Clause, which provides that no State may "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has a substantive as well as a procedural component: it not only imposes procedural safeguards against the arbitrary deprivation of life, liberty, or property, but also "bar[s] certain government actions regardless of the fairness of

the procedures used to implement them." *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986).

The Due Process Clause incorporates most of the rights protected by the Bill of Rights, *Duncan* v. *Louisiana*, 391 U.S. 145, 147-148 (1968), as well as certain common law rights that were protected at the time the Fourteenth Amendment was adopted. See *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261, 269-279 (1990). But "[n]either the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 848 (1992). See *Roe* v. *Wade*, 410 U.S. 113, 152-153 (1973); *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967); *Griswold* v. *Connecticut*, 381 U.S. 479, 481-482 (1965); *Pierce* v. *Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-403 (1923). This Court has recently stated that the task of defining the sphere of autonomy and personal dignity encompassed within the meaning of "liberty" ultimately requires a reliance on "reasoned judgment." *Casey*, 505 U.S. at 849.

The recognition of an interest as one encompassed within the meaning of the term "liberty" is a crucial first step in deciding whether a state policy violates substantive due process. The acknowledgement that a particular interest qualifies as a liberty interest for purposes of the Due Process Clause, however, does not invariably lead to the conclusion that the State is powerless to interfere with that interest. The question whether a statutory restriction on "liberty" violates the Constitution must be determined by assessing whether the State has an adequate justification for overriding the liberty interest at issue. The strength of the justification that is required depends upon the nature and character of the liberty

interest. *Cruzan*, 497 U.S. at 279 (liberty interest in refusing medical treatment must be balanced against the relevant state interests); *Williamson* v. *Lee Optical of Ok., Inc.*, 348 U.S. 483, 491 (1955) (state restriction affecting a person's ability to engage in a business must merely be rationally related to a legitimate government purpose); *Reno* v. *Flores*, 507 U.S. 292, 301-302 (1993) (infringement on certain fundamental liberty interests must be narrowly tailored to serve a compelling interest).

A. A Competent, Terminally Ill Adult Has A Liberty Interest In Obtaining Relief From Severe Pain Or Suffering

1. " 'Substantive due process' analysis must begin with a careful description of the asserted right." *Flores*, 507 U.S. at 302. The complaint in this case alleged that "[t]he Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. We do not agree that this Court's decisions support the conclusion that there is a broad liberty interest in deciding the timing and manner of one's death. The term "liberty" in the Due Process Clause, however, is broad enough to encompass an interest on the part of terminally ill, mentally competent adults in obtaining relief from the kind of suffering experienced by the plaintiffs in this case, which includes not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily and mental functions.

2. This Court's cases leave no doubt that when the State itself inflicts severe pain or suffering on someone, a liberty interest is implicated. *Ingraham* v. *Wright*, 430

U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when severe pain or suffering is caused by an illness, but the State compels a person to remain in that condition by prohibiting access to medication that would alleviate that condition. For example, in the absence of a subordinating government interest, a State could not prevent a person in extreme pain from obtaining from a qualified physician a medication demonstrated to be safe and effective in alleviating pain. Similarly, the State could not deny to persons suffering from severe and chronic depression access to safe and effective drugs that would relieve that debilitating condition. When the effect of a state prohibition is to prevent a person from ameliorating severe suffering, the State interferes with a liberty interest protected by the Due Process Clause. See *Casey*, 505 U.S. at 852 (among many other things, a prohibition on abortion interferes with a woman's liberty interest in avoiding potential physical and mental suffering associated with unwanted pregnancy and government-compelled childbirth).

3. *Cruzan* supports the conclusion that a liberty interest is at stake in this case. In *Cruzan*, the Court addressed the question whether the term "liberty" includes an interest in refusing medical treatment, even when the treatment is life-sustaining and its withdrawal would likely lead to a person's death. The Court noted that its prior decisions had established that a competent person has a liberty interest in refusing medical treatment, and it concluded that "the logic of th[ose] cases * * * would embrace a liberty interest" in refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279. The Court added that "[t]he choice between

life and death is a deeply personal decision of obvious and overwhelming finality." *Id.* at 281.

Although this case does not involve a liberty interest of the magnitude of that at stake in *Cruzan*—avoiding invasions of bodily integrity—it nonetheless implicates a significant liberty interest: avoiding severe pain or suffering. The lesson of *Cruzan* is that once such a liberty interest is acknowledged to exist, it persists even at the point at which avoiding severe pain and suffering coalesces with ending life. That "dramatic consequence[]" is taken into account in deciding whether the State's interest outweighs the interference with liberty. 497 U.S. at 279.

4. We disagree with the court of appeals' equation of the right to choose an abortion with the liberty interest at stake in this case. Pet. App. A56-A57. The fundamental right to choose an abortion rests on a combination of constitutionally protected interests, of which avoiding the pain and suffering associated with being forced to continue an unwanted pregnancy is but one part. A prohibition on abortion interferes with personal autonomy in an extremely consequential way: by forcing a woman to continue an unwanted pregnancy, the State requires a woman to undertake the birth of, and responsibility for, another person in a way that has no counterpart in our laws. The decision whether to have a child has life-long spiritual, moral, psychological, and legal consequences for both the woman and any child she may bear. The bearing of an unwanted child is fraught with the potential for "cruelty to the child" and "anguish to the parent." *Casey*, 505 U.S. at 853.

The right to choose an abortion, moreover, stands at the intersection of constitutional liberty and constitutional equality. "Requiring women to bear unwanted children threatens to lock them into a traditional and subordinate role, embodies assumptions about their inability to make

autonomous moral choices, and burdens women as a group with obligations that have no counterpart in the burdens that the State demands from men." Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay On Roe, Casey, And The Right To Die*, 44 Am. U.L. Rev. 803, 849 (1995) (Kreimer). There is therefore a profound equal protection dimension to the right to choose an abortion that is wholly absent here. See *Casey*, 505 U.S. at 852 (stating that a woman's "suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture"); *id.* at 856 ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."). The right to choose an abortion thus implicates the liberty of a woman "in a sense unique to the human condition and so unique to the law." *Id.* at 852.

Because the right to choose an abortion implicates a constellation of liberty and equality rights of fundamental constitutional importance, the court of appeals erred in equating the right at issue in this case with that right. There is nonetheless, for the reasons we have discussed, a liberty interest at stake in this case: a State may not, without adequate justification, prevent a person from obtaining relief from severe suffering.

5. The conclusion that a liberty interest is at stake in this case cannot be avoided by the assertion that terminally ill patients can receive relief from their pain without taking lethal doses of medication. There are some few patients whose pain cannot be alleviated.[1] There is,

---

[1] While most terminally ill persons can obtain relief from extreme pain through palliative treatment, studies show that an "irreducible core of patients are trapped in physical agony (if they are awake)."

moreover, suffering beyond physical pain for some in the terminal stages of illness. A patient in the terminal phase of a disease may suffer from several serious conditions that may not be fully treatable, including the constant sensation of suffocation, the inability to sleep, the loss of appetite, and nausea. New York State Task Force Report on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40-41 (1994) (*Task Force Report*); Pet. App. E3-E4. Most important, perhaps, the inability to exercise control over bodily or mental functions can itself be a source of great despair. A constitutionally protected liberty interest is at stake for all these persons.

B. Overriding State Interests Justify The State's Decision To Ban Physicians From Prescribing Lethal Medication

As previously discussed, the question of whether an individual's constitutional rights have been violated must be determined by assessing whether the interests asserted by the State in support of a restriction on liberty override the individual's interest in liberty. In some contexts, a State may justify an interference with liberty by offering no more than a rational and legitimate justification. *Williamson*, 348 U.S. at 491. In other circumstances, the State must show that any restriction is narrowly tailored to further a compelling interest. *Flores*,

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Kreimer, 44 Am. U.L. Rev. at 831 & n.93 (pain can be effectively controlled in up to 90% of all cancer patients); The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 & n.18 (1994) (pain can be effectively controlled in 90%-95% of all cases; in the remaining cases, the reduction of pain would require sedation into a sleep-like state, an option that is considered only in the last days or weeks of a person's life).

507 U.S. at 301-302. And in still other contexts, an intermediate standard is applied in which the individual's "liberty interests" are "balance[d] * * * against the relevant state interests." *Cruzan*, 497 U.S. at 279; *Youngberg* v. *Romeo*, 457 U.S. 307, 321 (1982). For reasons discussed, pp. 24-25, *infra*, there are important differences between the liberty interest in refusing medical treatment recognized in *Cruzan* and the interest in avoiding severe pain or suffering at issue here. Nonetheless, the interest in avoiding the suffering or pain of terminal illness may be sufficiently analogous to the interest in refusing medical treatment to justify the application of the same legal standard for determining whether the State's interests are overriding. Measured by that standard, the state interests supporting the ban on assisted suicide are sufficient to justify the limitation on liberty embodied in that prohibition.

1. The State of Washington does much to accommodate the liberty interest of a competent, terminally ill adult in obtaining relief from severe pain or suffering. The State permits terminally ill, competent adults to refuse unwanted medical treatment when it is offered and to order the withdrawal of such treatment if it has already begun. Wash. Rev. Code §§ 70.122.010-70.122.030 (1994). Equally important, the ethical standards of the medical community have long permitted physicians to prescribe medication in sufficient doses to relieve pain, even when the necessary dose will hasten death. AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* § 2.20 (1989). So long as the physician's intent is to relieve pain, and not to cause death, such treatment does not violate the ethical standards of the medical community. *Ibid.* The question presented in this case is whether the State is constitutionally required to take the additional step of permitting physicians to prescribe lethal medica-

tion for competent, terminally ill adults, when the acknowledged purpose of the prescription is to end the patient's life.

2. As a general matter, the State unquestionably has an interest of the highest order in prohibiting its physicians from assisting in the purposeful taking of another life. "[T]he States—indeed all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280. In addition, the Due Process Clause itself "protects an interest in life" as well as an interest in obtaining relief from pain and suffering. *Id.* at 281. The question is whether the Constitution requires a State to make an exception to its general policy of protecting life in the class of cases in which a competent, terminally ill adult voluntarily requests life-ending medication in order to obtain relief from severe pain or suffering. The case for such an exception strikes a responsive chord in many people.

Responsible and fair-minded legislators, however, must not only concern themselves with the effect that a prohibition against assisted suicide will have on the class of persons identified by the court of appeals. They must also concern themselves with the effects that creating an exception to that prohibition would have on others. One difficult question for lawmakers, including those who believe that the prescription of life-ending medication is defensible in some circumstances, is whether an exception can be created for persons like the plaintiffs in this case without endangering the lives of many other persons who do not satisfy the criteria specified by the court of appeals. The State must attempt to decide, in the face of much uncertainty, whether the creation of an exception to its

prohibition against providing lethal medication for the competent, terminally ill adults who voluntarily request the assistance will lead to the deaths of many persons who are not competent, who are not terminally ill, and who do not make truly voluntary requests for assistance. At this point in our history, there is little doubt that a legislature may responsibly decide that making lethal medication available for some "would create widespread and unjustified risks for many others." *Task Force Report* at 135. A State therefore may conclude that it has an overriding interest in maintaining a prohibition against all assisted suicides.[2]

a. One special source of concern is that terminally ill persons who contemplate suicide often suffer from undiagnosed depression and inadequately treated pain. *Task Force Report* at 126-128. In most cases, once appropriate treatment is provided, the desire for suicide abates. As explained in the *Task Force Report*, "[g]iven access to appropriate relief from pain and other debilitating symptoms, many of those who consider suicide during the course of a terminal illness abandon their desire for a quicker death in favor of a longer life made more tolerable with effective treatment." *Id.* at 120-121.

It is perhaps possible to posit a world in which physicians who treat terminally ill patients could readily distinguish between requests for suicide that stem from treatable depression and pain and requests that are based

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[2] This Court therefore need not decide, in the abstract, whether the State has an overriding interest in protecting the life of a competent, terminally ill adult who makes a voluntary decision to seek lethal medication in order to alleviate severe pain or suffering that is not treatable. That question would have to be decided only if it were clear that creating an exception from the prohibition against assisted suicide for such persons would not lead to the deaths of other persons whom the State has an unquestionable interest in protecting.

on severe pain and suffering that is not treatable. But "the reality of existing medical practice in doctors' offices and hospitals * * * cannot match th[ose] expectations." *Task Force Report* at 120. The truth is that physicians often fail to detect treatable depression in terminally ill patients and that they undermedicate persons in pain. *Id.* at 127-128. Any exception to the ban on assisted suicide therefore runs a very significant risk that persons with treatable depression and pain will be allowed to commit suicide. A State has an overriding interest in avoiding that risk and in protecting persons who would want to remain alive if provided with the appropriate treatment. That interest is directly implicated here, and the State could responsibly conclude that the appropriate way to serve that interest is by continuing to prohibit all assisted suicides.

b. Another area of concern is that terminally ill patients are often extremely vulnerable and susceptible to influence by physicians, family members, and others on whom they depend for support. A terminally ill person may have a strong desire to remain alive. But if that person perceives that those around him disapprove of that choice, it may be difficult to remain steadfast in that choice. The problem is even greater if the patient begins without a strong resolve to cling to life. The point is not that physicians or family members will attempt to coerce persons into committing suicide, although there may be some cases of that. The real dangers are much more subtle and extremely difficult to monitor and address.

For example, physicians may offer lethal medications based on their own judgments concerning the quality of the person's life and their own belief that any rational person in that condition would want assistance in committing suicide. *Task Force Report* at 124-125. Physicians may readily accept a person's request for suicide,

rather than offering emotional support for a decision to remain alive because of their "own frustration in situations when medicine can provide care but not cure." *Id.* at 123. Pressures to cut costs can also affect judgment. When the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former. *Ibid.* "Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy." Kreimer, 44 Am. U.L. Rev. at 841.

Many terminally ill patients are under the care of physicians with whom they have personal relationships, and many of those physicians have the time, energy, and sensitivity to help patients who request assisted suicide in making a truly voluntary decision about their treatment options. Such physicians know that terminally ill patients often voice a desire to commit suicide as a way of seeking confirmation that there is still value to their lives. *Task Force Report* at 128. And when physicians affirm that the patient's life continues to be valued and devote the necessary time to bring that point home, patients often respond with a renewed sense of purpose. *Id.* at 129. In the real world, however, patients do not always receive advice from sensitive and caring physicians. That advice also comes from doctors who are "harried," who are "uncomfortable talking about dying," who are "unable to distinguish their views from the values and needs of their patients," or who are dealing with patients "with whom they have had little contact and for whom they hold no hope of recovery." *Id.* at 130.

The involvement of family members in decisions about a terminally ill relative presents a very different set of concerns. Providing care and support to a terminally ill fam-

ily member can exact an enormous financial and emotional toll. *Task Force Report* at 124. Undertandably, some family members, at some point, may hope that a lingering illness that has left a loved one in a debilitated state will come to a quick end. "Close family members may have a strong feeling—a feeling not at all ignoble or unworthy, but not entirely disinterested, either—that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading." *Cruzan*, 497 U.S. at 286. Even those determined to keep such thoughts to themselves can have difficulty hiding their true feelings from the ones they love. Those who are terminally ill may come to feel that their only real choice is to comply with the unstated wishes of their family members by seeking a lethal prescription. *Task Force Report* at 124.

c. Another difficulty with permitting doctors to prescribe lethal drugs for terminally ill patients is that illnesses can be misdiagnosed as terminal. In fact, "[a] surprising number of people have had the experience of being misinformed that they had a terminal illness." Richard A. Posner, *Aging and Old Age* 245 (1995) (Posner). If the State were to create an exception to its ban on assisted suicide for terminally ill adults, such a misdiagnosis could have tragic consequences. That is particularly true in cases in which lethal medication has been sought by persons only because they were mistakenly informed that they were suffering from a terminal disease. The State has an overwhelmingly strong interest in preventing such tragedies from occurring.

d. The court of appeals acknowledged the State's important interest in protecting the lives of those who do not really wish to die, but who request lethal drugs from their doctors because of real or perceived pressure from others to choose death. Pet. App. A84. The court concluded, however, that the State should address that concern through procedural safeguards. *Id.* at A102-A103. A State is not constitutionally precluded from attempting to deal with the issue of voluntariness through procedural safeguards. But a State could also fairly decide that, in light of the special vulnerability of terminally ill patients and the many subtle ways in which physicians and family members can influence them, a scheme of procedural safeguards would not be effective in ensuring that choices about death are truly voluntary. To prevent the very real danger that persons who want to live will feel unduly pressured to choose death, the State may decline to give its imprimatur to physician assisted suicides through lethal medications.

In gauging the strength of a State's interest in enacting a categorical ban on assisted suicide in order to protect the lives of persons outside the class of persons described by the court of appeals, it is useful to examine the experience of the Netherlands. In that country, doctors are not subject to legal sanctions for assisting suicide where the patient's request is persistent and voluntarily made, where the patient's condition is beyond recovery or amelioration, and where the doctor has consulted with a colleague to ensure that the relevant criteria have been satisfied. Burial and Cremation Act, Stb. § 10 App. (1994); see also Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands* 25-44 (1991). All physician assisted deaths must also be reported. Burial and Cremation Act, Stb. § 10 (1994).

A recent study shows that those procedural safeguards have not worked. In 1990, more than one-half of assisted deaths were not even reported. Yale Kamisar, *Against Assisted Suicide—Even A Very Limited Form*, 72 U. Det. L. Rev. 735, 752 (1995) (Kamisar). More troubling, there were 1000 cases in which physicians had taken the

patient's life without having received an explicit request. *Ibid.*

There are dangers in relying too heavily on the experience of another country in predicting what would happen if physician assisted suicide were permitted in this country. But the Netherlands experience is the only test thus far of whether procedural safeguards can adequately protect the State's interest in protecting the lives of those who fall outside the class of persons described by the court of appeals.

3. As we demonstrate more fully in our amicus brief in *Vacco* v. *Quill*, No. 95-1858, the strength of the State's interest in this case is not diminished by the fact that the State permits competent, terminally ill adults to refuse life-saving treatment. There are important distinctions between the two. First, there is a very significant distinction between removing artificial supports—and thereby allowing the underlying disease to progress to its inevitable end—and providing chemicals to kill someone. In one case, the cause of death can reasonably be viewed as the underlying disease; in the other, the cause of death can only be viewed as the lethal medication. That important, common-sense distinction is reflected in the laws of at least 40 states that permit the withdrawal of life-sustaining treatment, but prohibit the prescription of lethal drugs. Compare Pet. App. A68 & n.77 (listing States that permit the withdrawal of life-sustaining treatment) with *id.* at A135-A136 & nn.10-12 (listing States that prohibit assisted suicide). The distinction may not be completely satisfying in all of its applications, but it is entirely logical in the vast majority of cases.

The imposition of life-saving treatment also involves a significantly more serious interference with personal liberty than a prohibition against lethal prescriptions. To force upon an unwilling patient artificial, invasive means

of life-support is not only to transgress the "sacred * * * right of every individual to the possession and control of his own persons," *Cruzan*, 497 U.S. at 269 (quoting *Union Pac. Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891), but to force upon the patient a condition of total physical dependence in which his bodily existence may be literally taken over by machines.

As in the case of physician-provided lethal medications, there are risks that extending a right to refuse life-sustaining treatment to competent, terminally ill persons who voluntarily request it may endanger the lives of persons outside that class. But the risks are significantly less serious in both kind and degree. The prescription of life-ending drugs leaves no opportunity to correct a misdiagnosis of terminal illness. In contrast, when life-sustaining treatment is withdrawn, certain death does not follow if the diagnosis of terminal illness is mistaken. More important, the class of persons at risk of making a decision that is not competent or truly voluntary when a State recognizes a right to refuse treatment is self-limiting: the risk extends only to those who would die without treatment—many of whom are in hospitals or nursing homes. While that is not an insignificant number of people, permitting assisted suicide would extend that risk to a much larger group of persons in circumstances that may be much more difficult to monitor.

Thus, there are constitutionally significant differences between refusing medical treatment and obtaining lethal medication. Accordingly, while competent, terminally ill adults have a constitutional right to refuse life-saving medical treatment that the State may not override, see *Casey*, 505 U.S. at 857, we believe that such persons have no corresponding constitutional right to obtain lethal medication. In the latter context, in our view, a State may decide that its interests are overriding.

4. Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point. Indeed, "[m]ost proposals to legalize assisted suicide have rejected terminal illness as the dividing line because it would not respond to many circumstances that can cause the same degree o[f] pain and suffering." *Task Force Report* at 132. Once the exception is expanded to anyone who suffers from severe pain and suffering, however, it may become difficult to contain effectively. *Ibid.*

Moreover, once a categorical prohibition against prescribing lethal medication to assist suicide is lifted, it may be difficult to justify a categorical prohibition against permitting physicians to administer lethal medication themselves (usually referred to as active euthanasia). When a person experiencing severe pain or suffering requests life-ending medication, but is physically unable to take the medication himself, active euthanasia is the only possible way to satisfy his request. Timothy Quill, a leading advocate of physician assisted suicide and a respondent in the New York case presently before the Court (No. 95-1858), initially opposed active euthanasia on the ground that it created unacceptable risks of abuse not present when the final act is solely the patient's. Kamisar, 72 U. Det. L. Rev. at 747-748. Two years later, however, Dr. Quill changed his mind, arguing that a prohibition against physician administered life-ending medication unfairly discriminates against patients with unrelievable suffering who resolve to end their lives but are physically unable to do so. *Id.* at 748. The court of appeals in this case similarly noted that any distinction between a physician prescribing lethal medication and a physician administering such medication would be difficult to maintain. Pet. App. A100-A101.

The extraordinary difficulty in drawing fully defensible lines in this area is significant. The line between withdrawing life-saving treatment and providing lethal medication may not be fully satisfactory in all of its applications. But it is at least as reasonable as any other line that could be drawn. In such circumstances, there is no basis for a court to invalidate the line drawn by the State.

5. When a State seeks to reconcile the liberty interests of some people with the risk of death to others, it must be given some latitude in drawing the appropriate line. See *Youngberg*, 457 U.S. at 320, 322-323. That is particularly true in this context, where there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way. Posner at 260-261.[3] Terminal illness does not single out any discrete or insular minority; it potentially affects all Americans—all races, both genders, and every income group. All legislators must face the possibility that they will one day suffer from a terminal illness; there are no immunities from that fate. There is, in sum, no constitutional basis for preempting the continuing legislative reexamination of the urgent issues involved in this case.

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[3] States have begun to consider anew the issue of physician assisted suicide, and there is no indication that the political processes are malfunctioning. Voters in the State of Oregon approved a ballot initiative permitting physician assisted suicide in November 1994. Pet. App. A49. Initiatives in California and Washington were rejected, but they were supported by 46% of the voters. *Ibid.* And "[p]roposals to permit physician-assisted suicide have also been introduced in Iowa, Maine, Michigan, and New Hampshire." *Id.* at A49 n.52.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF OF *AMICI CURIAE* STATES OF CALIFORNIA, ALABAMA, COLORADO, FLORIDA, GEORGIA, ILLINOIS, IOWA, LOUISIANA, MARYLAND, MICHIGAN, MISSISSIPPI, MONTANA, NEBRASKA, NEW HAMPSHIRE, NEW YORK, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, AND VIRGINIA AND THE COMMONWEALTH OF PUERTO RICO IN SUPPORT OF PETITIONERS STATE OF WASHINGTON, ET AL.

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INTEREST OF THE *AMICI* STATES

Over a century ago, this Court, describing the dual sovereignty of the States and Federal Government, declared that:

> The preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National government. The Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States.[1]

Respect for state sovereignty and the power of the people to directly govern their own affairs, unless excluded by the Constitution or valid Act of Congress, is the embodiment of our federalism.[2] It is this understanding of federalism which ensured ratification of the Constitution and which safeguards the essential role of the States in our federal system. There have been few cases in which this understanding of federalism has been disregarded as completely as in the case below.

In the history of our Nation, no court of final jurisdiction has ever declared the existence of a constitutional right or interest to commit suicide or assisted suicide.[3] However, in a radical departure from our Nation's history and tradition, and contrary to the laws of an overwhelming majority of States, the Ninth Circuit has announced its discovery of new rights to commit suicide and assisted suicide imbedded in the Due

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[1] *Texas v. White*, 7 Wall. 700, 725 (1869), *quoting Lane County v. Oregon*, 7 Wall. 71, 76 (1869).

[2] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people." U.S. Const. amend. X.

[3] The Second Circuit has rejected the claim that there is a liberty interest in assisted suicide under the Due Process Clause of the Fourteenth Amendment. *Quill v. Vacco*, 80 F.3d 716, 723-725 (2d Cir. 1996) (hereinafter "*Quill*"), *cert. granted*, ___ U.S. ___ (1996 WL 282544) (1996). The Second Circuit did, however, invalidate New York's prohibition of assisted suicide on equal protection grounds. *Quill*, 80 F.3d at 725-731.

Process Clause of the Fourteenth Amendment.[4] The Ninth Circuit's holding strikes at the very heart of this Court's federalism jurisprudence and, upon review, falls far short of overcoming that "great resistance" to expansion of the substantive content of the Due Process Clause. *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986). It also "calls for some judgment about the limits of the [Judiciary's] role in carrying out its constitutional mandate." *Bowers*, 478 U.S. at 190.

At stake in this case are, first and foremost, the lives of the people, both those who wish to die and those who wish to live no matter what their circumstances. Also at stake is the sovereign power of the States to protect and preserve those lives without a federal requirement that the State "make judgments about the 'quality' of life that a particular individual may enjoy, . . . " *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 (1990). The Court's decision in this case will directly affect the people of all the States of the Union. It will also determine whether "the States *as States* have [any] legitimate interests which the National Government is bound to respect even though its laws are supreme." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 581 (1985) (O'Connor, J., dissenting) (italics original, citation omitted, insert added).

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[4] *Compassion in Dying v. State of Washington*, 79 F.3d 790, 793-794 (9th Cir. 1996) (*en banc*) (hereinafter "*Compassion in Dying II*"), *cert. granted*, ___ U.S. ___ (1996 WL 411596) (1996). A limited eleven-judge *en banc* panel vacated the previous decision of the three-judge panel, reported at *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995) (hereinafter "*Compassion in Dying I*"), which had voted 2-1 to reverse the district court decision, reported at 850 F.Supp. 1454 (W.D. Wash. 1994). Thereafter, an active judge *sua sponte* requested that the full court *en banc* rehear the case; however, that request failed to receive a majority of the votes of the non-recused active judges and was rejected. Dissenting opinions from the order rejecting the request for rehearing were filed by Circuit Judges O'Scannlain and Trott. *Compassion in Dying v. State of Washington*, 85 F.3d 1440 (9th Cir. 1996).

SUMMARY OF ARGUMENT

Americans today often speak in terms of their "right" to engage in particular conduct. However, "words [such] as 'right' are a constant solicitation to fallacy." *Jackman v. Rosenbaum Co.*, 260 U.S. 22, 31 (1922). In this case, respondents claim that patients have a "right to die." "The mere novelty of such a claim is reason enough to doubt that substantive due process sustains it; . . . " *Reno v. Flores*, 507 U.S. 292, 303 (1993). Indeed, the framers of the Fourteenth Amendment would be profoundly amazed if they were told that the liberty they sought to preserve for the newly freed slaves encompassed a liberty to kill oneself and, further, a liberty to receive the assistance of another to do so.[5] As discussed below, in order to sustain respondents' novel claim, the Ninth Circuit had to create a new standard for substantive due process adjudication and, in the process, committed a series of fundamental errors.

The threshold error was the Ninth Circuit's failure to carefully identify the specific conduct at issue, *i.e.*, suicide and assisted suicide. That failure, coupled with the broad approach utilized by the Ninth Circuit, opened the door to consideration of a host of activities which are wholly dissimilar from suicide and assisted suicide and which plainly involve different considerations.

The Ninth Circuit's discovery of new liberty interests in suicide and assisted suicide is unsupported by the plain language of the Due Process Clause, antithetical to its design, and unsupported by any previous decision of this Court. Indeed, this Court has never before recognized a "liberty" interest to extinguish the life of a "person" as that word is used in the Fourteenth Amendment. It is this critical difference between abortion and assisted suicide which exposes the fundamental error of seeking to create new liberty interests in

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[5] *McLaughlin v. Florida*, 379 U.S. 184, 191-192 (1964) ("the historical fact [is] that the central purpose of the Fourteenth Amendment was to eliminate racial discrimination emanating from official sources in the States. [insert added]").

suicide and assisted suicide by analogizing to the unique abortion rights jurisprudence.

There can be no doubt that opposition to suicide and assisted suicide is deeply rooted in our Nation's history and tradition. Furthermore, the Ninth Circuit failed to even consider whether suicide and assisted suicide are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-326 (1937) (citation omitted). Instead, the Ninth Circuit fashioned a new standard for substantive due process adjudication premised on three sentences taken from *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and the limited holding of the Court in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). That new standard, which is based on a concept of autonomous self-determinism, ignores both our Nation's history and tradition with respect to suicide and assisted suicide and, at the same time, "the demands of organized society." *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting).

Finally, the Ninth Circuit purported to limit its newly discovered interests in suicide and assisted suicide to just terminally ill, mentally competent adults. However, if, as the Ninth Circuit found, personal autonomy and the right to refuse unwanted medical treatment are the roots for these new liberty interests, such a limitation is plainly insupportable. In short, the decision below does not simply push the States down the so-called "slippery slope" – it hurls them over the precipice into a bottomless pit of constitutional litigation where they will spend decades litigating the parameters of these newly discovered liberty interests in suicide and assisted suicide.

With the ever-increasing power of medical science to prolong life, even in the face of what would otherwise be terminal illness, the States have had to strike a balance between the rights of the individual and "the demands of organized society." *Poe*, 367 U.S. at 542 (Harlan, J., dissenting). That balance is grounded in the States' recognition of their responsibility to protect both individual liberty and, at the same time, the lives of the people, both those who wish to die and those who wish to live no matter what their circumstances.

In striking that balance, the States have drawn a line between an individual's right to refuse unwanted medical treatment and intentionally killing oneself, with or without assistance. That balance, now a national consensus, is represented by statutes in a majority of States which recognize an individual's right to refuse unwanted medical treatment and, at the same time, reject any affirmative act to end life.[6] Whether that balance

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[6] Today, forty-seven state legislatures make the fundamental distinction between refusal of unwanted life-sustaining medical treatment and the act of suicide in their natural death/living will statutes: Ala. Code § 22-8A-10 (1990); Alaska Stat. § 18.12.080(f) (Michie 1994); Ariz. Rev. Stat. Ann. § 36-3210 (West Supp. 1995); Ark. Code Ann. § 20-17-210(g) (Michie 1991); Cal. Health & Safety Code § 7191.5(g) (West Supp. 1996); Colo. Rev. Stat. § 15-18-112(1) (West 1987); Fla. Stat. Ann. § 765.309(1) (West Supp. 1996); Ga. Code Ann. § 31-32-11(b) (1996); Haw. Rev. Stat. § 327D-13 (Supp. 1992); Ill. Comp. Ann. Stat. ch. 755, § 35/9(f) (Smith-Hurd 1992); Ind. Code Ann. § 16-36-4-19 (West Supp. 1996); Iowa Code Ann. § 144A.11.6 (West 1989); Kan. Stat. Ann. § 65-28,109 (1992); Ky. Rev. Stat. Ann. § 311.639 (Michie 1995); La. Rev. Stat. Ann. § 40:1299.58.10(A) (West 1992); Me. Rev. Stat. Ann. tit. 18-A, § 5-813(c) (West Supp. 1995); Md. Health-Gen. Code Ann. § 5-611(c) (1994); Minn. Stat. Ann. § 145B.14 (West Supp. 1996); Miss. Code Ann. § 41-41-117(2) (1993); Mo. Ann. Stat. § 459.055(5) (West 1992); Mont. Code Ann. § 50-9-205(7) (1995); Neb. Rev. Stat. Ann. § 20-412(7) (Michie 1995); Nev. Rev. Stat. Ann. § 449.670(2) (Michie 1991); N.H. Rev. Stat. Ann. § 137-H:13 (1996); N.C. Gen. Stat. § 90-320(b) (1993); N.D. Cent. Code § 23-06.4-01 (1991); Ohio Rev. Code Ann. § 2133.12(D) (Anderson Supp. 1995); Okla. Stat. Ann. tit. 63, § 3101.12(G) (West Supp. 1996); Pa. Cons. Stat. Ann. tit. 20, § 5402(b) (West Supp. 1996); R.I. Gen. Laws § 23-4.11-10(f) (Supp. 1995); S.C. Code Ann. § 44-77-130 (Law Co-op. Supp. 1996); S.D. Codified Laws Ann. § 34-12D-20 (Michie 1994); Tex. Health & Safety Code Ann. § 672.020 (West 1992); Utah Code Ann. § 75-2-1118 (1993); Va. Code Ann. § 54.1-2990 (Michie 1994); Wash. Rev. Code Ann. § 70.122.100 (West Supp. 1996); W.Va. Code § 16-30-10 (1995), *see also* § 16-30C-14 (1995)(DNR orders); Wis. Stat. Ann. § 154.11(6) (West 1989); Wyo. Stat. § 35-22-109 (Michie 1994). *See also* D.C. Code Ann. § 6-2430 (1989); or in their durable power of attorney for health care acts: Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981); Idaho Code § 39-152 (Supp. 1996) (DNR orders); Ill. Comp. Stat. Ann. ch. 755, § 40/50 (Smith-Hurd 1992); Ind. Code Ann. §§ 16-36-1-12(c), 16-36-1-13

should be abandoned and the line redrawn to permit an individual to commit suicide without state interference, and then redrawn yet again to permit assisted suicide, is a matter appropriately left for the people to decide, through their duly elected representatives or by initiative ballot.[7] The principles of federalism embodied in our Constitution require no less.

ARGUMENT

I. THERE IS NO LIBERTY INTEREST UNDER THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT TO COMMIT SUICIDE OR ASSISTED SUICIDE

The issue presented in this case is whether there is a liberty interest under the Due Process Clause of the Fourteenth Amendment to commit suicide and, if so, whether it includes an interest to receive the assistance of another to do so. The novelty of respondents' claim serves to highlight the importance of the cautionary note, expressed by the Court in *Bowers v. Hardwick*, which governs all substantive due process adjudication:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The

(West Supp. 1996), *see also* § 30-5-5-17(b) (West 1994); Iowa Code Ann. § 144B.12.2 (West Supp. 1996); Mass. Gen. Laws Ann. ch. 201D, § 12 (West Supp. 1996); Mich. Comp. Laws Ann. § 700.496(20) (West 1995); N.Y. Pub. Health Law § 2989(3) (McKinney 1993); N.D. Cent. Code § 23-06.5-01 (1991); R.I. Gen. Laws § 23-4.10-9(f) (Supp. 1995); Wyo. Stat. § 3-5-211 (Michie Supp. 1996); or both: *See also* Conn. Gen. Stat. Ann. § 19a-575 (West Supp. 1996) (form declarations); N.J. Stat. Ann. § 26:2H-54(d)-(e) (West 1996) (legislative findings); N.M. Stat. Ann. § 24-7A-13(C) (Michie Supp. 1995).

[7] *See People v. Kevorkian*, 447 Mich. 436, 481-482, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr.2d 59, 64 (1992). *See also Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. banc 1988) ("Broad policy questions bearing on life and death issues are more properly addressed by representative assemblies."), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

> Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

Bowers v. Hardwick, 478 U.S. 186, 194-195 (1986).

The Court recently reaffirmed that "great resistance" in *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992), declaring that "[a]s a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended. [citation omitted]" Mindful of that "great resistance", it is of critical importance that lower courts carefully adhere to the principles established by this Court when construing the substantive content of the Due Process Clause. Unfortunately, as discussed below, the Ninth Circuit failed in this regard.

A. The Ninth Circuit's Constitutional Analysis Was Fundamentally Flawed At The Threshold By Its Failure To Carefully Identify The Specific Conduct At Issue

In the perilous waters of substantive due process adjudication, a carefully focused approach helps to eliminate the irrelevant, illuminate the pertinent, and insure that the discovery of new rights is "much more than the imposition of the Justices' own choice of values on the States and Federal Government, . . . " *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986). Indeed, the Court has made clear that " '[s]ubstantive

due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.' " *Reno v. Flores*, 507 U.S. 292, 302 (1993) (citations omitted). Thus, in *Bowers*, the Court carefully focused on the specific conduct at issue when it framed the question presented as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time." *Bowers*, 478 U.S. at 190. The focus of the Court's inquiry was not whether one has a right to engage in sexual conduct of one's choice but, rather, whether the specific conduct at issue – homosexual sodomy – was entitled to constitutional protection. Likewise, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the Court carefully focused on whether Nancy Cruzan had "a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under [her] circumstances." *Cruzan*, 497 U.S. at 269 (insert added). This carefully focused approach allowed the Court to first identify the specific conduct at issue, *i.e.*, the withdrawal of unwanted life-sustaining medical treatment, and then the relevant historical traditions, *i.e.*, the doctrine of informed consent (which encompasses the notion of bodily integrity), protecting or denying protection to that specific conduct.

Rather than carefully focusing on suicide and assisted suicide, the Ninth Circuit broadly framed the question presented as "whether there is a liberty interest in determining the time and manner of one's death." *Compassion in Dying II*, 79 F.3d at 800. By doing so, it opened the door to consideration of a host of activities which are wholly dissimilar from suicide and assisted suicide and which plainly involve different considerations. Indeed, even the Ninth Circuit acknowledged that "[t]he liberty interest we examine encompasses a whole range of acts that are generally not considered to constitute 'suicide.' " *Compassion in Dying II*, 79 F.3d at 802.

In sharp contrast to the Ninth Circuit's broad approach, other courts which have considered this identical question

have utilized a carefully focused approach consistent with the precedents of this Court.[8] The Ninth Circuit's rationale for broadly framing the question presented was its belief that "it is the end and not the means that defines the liberty interest." *Compassion in Dying II*, 79 F.3d at 801. If true, the issues framed by this Court in *Bowers*, *Cruzan*, and *Reno v. Flores* were far too narrow. Rather, under the Ninth Circuit's new "end-result" standard for defining liberty interests, the issue in *Bowers* should have been whether there is a liberty interest to engage in sexual conduct of one's choice and, in *Cruzan*, whether there is a liberty interest to determine the time and manner of one's death. In fact, under the Ninth Circuit's new "end-result" standard, the issues in *Compassion in Dying II* and *Cruzan* should have been *identical*. In *Reno v. Flores*, respondents, a class of alien juveniles arrested by the Immigration and Naturalization Service on suspicion of being deportable and seeking a right to be routinely released into the custody of other "responsible adults," claimed a right to " 'freedom from physical restraint.' " *Reno v. Flores*, 507 U.S. 292, 299 (1993). Under the Ninth Circuit's new "end-result" standard, since "freedom from physical restraint" is the end sought to be achieved, that would be the proper description of the liberty interest at issue. However, that description was soundly rejected by this Court because it did not accurately identify the specific right or interest at issue. *Reno*, 507 U.S. at 302. Likewise, the question in the instant case is not "whether there is a liberty interest in determining the time and manner of one's death, . . . " *Compassion in Dying II*, 79 F.3d at 800. Rather, it is whether there is a liberty interest to commit suicide and, if so, whether it

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[8] *See, e.g., Quill*, 80 F.3d at 723 (Second Circuit carefully focusing on plaintiffs' argument "for a right to assisted suicide as a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment.") and *People v. Kevorkian*, 447 Mich. 436, 464, 527 N.W.2d 714, 724 (1994) (Michigan Supreme Court carefully focusing its inquiry on "whether the clause encompasses a fundamental right to commit suicide and, if so, whether it includes a right to assistance."), *cert. denied*, 115 S.Ct. 1795 (1995).

includes an interest to receive the assistance of another to do so.[9]

B. The Ninth Circuit's Discovery Of New Liberty Interests In Suicide And Assisted Suicide Is Not Supported By The Plain Language Or *Design* Of The Due Process Clause

The Due Process Clause of the Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law; . . . " U.S. Const. amend. XIV, § 1. Nowhere in the plain language of the Clause is an interest in committing suicide or assisted suicide expressly granted. Nor does the *design* of the Clause support any such contention.[10] The design of the Clause establishes life as the first interest to be accorded substantive and procedural protection, liberty the second, and property the third. The reason for this design is manifest: without life, liberty cannot exist and property cannot be acquired. Any finding of a "liberty" interest to extinguish the life of a "person," as that word is used in the Fourteenth Amendment, inverts the order and is directly contradicted by, and plainly inconsistent with, the design of the Clause itself.[11]

This Court has never before recognized a "liberty" interest to extinguish the life of a "person" as it understands that

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[9] *Cf. People v. Kevorkian*, 447 Mich. 436, 476 n.47, 527 N.W.2d 714, 730 n.47 (1994) ("The question presented in this case thus is not whether a person has a constitutional right of self-determinism, or a right to define personal existence, or a right to make intimate and personal choices, or a right not to suffer. Rather, the question that we must decide is whether the constitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance."), *cert. denied*, 115 S.Ct. 1795 (1995).

[10] "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language *or design* of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986) (emphasis added).

[11] *Cf.* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, 799, 807 (1994).

word to be used in the Fourteenth Amendment.[12] "[A] fundamental premise of our constitutional law governing reproductive autonomy" is the Court's holding in *Roe* that "an abortion is not 'the termination of life entitled to Fourteenth Amendment protection.' " *Planned Parenthood v. Casey*, 505 U.S. 833, 913-914 (1992) (Stevens, J., concurring in part and dissenting in part), *citing Roe v. Wade*, 410 U.S. 113, 159 (1973). Indeed, in discussing its earlier decision in *United States v. Vuitch*, 402 U.S. 62 (1971), the Court made clear in *Roe* that it "would *not* have indulged in statutory interpretation favorable to abortion in specified circumstances *if the necessary consequence was the termination of life entitled to Fourteenth Amendment protection.*" *Roe*, 410 U.S. at 159 (emphasis added).

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[12] *See* Charles Warren, *The New "Liberty" Under The Fourteenth Amendment*, 39 Harv. L. Rev. 431, 439-445 (1926) (discussing decisions between 1789 and 1926 in which the term "liberty" has been construed by the Court). *See also Meyer v. Nebraska*, 262 U.S. 390 (1923) ("right to choose and pursue a given legitimate vocation"); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (upbringing and education of children); *Skinner v. Oklahoma*, 316 U.S. 535 (1942) (procreation); *Prince v. Massachusetts*, 321 U.S. 158 (1944) (family relationships); *Griswold v. Connecticut*, 381 U.S. 479 (1965) (use of contraceptives by married couples); *Loving v. Virginia*, 388 U.S. 1 (1967) (marriage); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (use of contraceptives by unmarried couples); and *Roe v. Wade*, 410 U.S. 113 (1973) (decision of a woman to seek an abortion before fetus attains viability). In *Cruzan*, the Court did not explicitly recognize a liberty interest to terminate the life of a person entitled to Fourteenth Amendment protection; rather, it *assumed* a liberty interest, based on the doctrine of informed consent and notion of bodily integrity, to refuse unwanted life-sustaining medical treatment, regardless of the consequences of that refusal. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279 (1990). Moreover, since the patient's death is caused by his/her underlying terminal illness when unwanted life-sustaining medical treatment is refused or withdrawn, and not by any affirmative act intended to extinguish life, the assumed liberty interest recognized in *Cruzan* can in no way be considered the equivalent of a liberty interest to terminate the life of a person entitled to Fourteenth Amendment protection.

That is precisely the "necessary consequence" which this Court is confronted with in the instant case: "the termination of life entitled to Fourteenth Amendment protection." *Id.* Unsupported by the plain language of the Clause, antithetical to its design, and unsupported by any previous decision of this Court, there must necessarily be a strong presumption against the contention that a liberty interest to extinguish the life of a person entitled to Fourteenth Amendment protection can nevertheless be implied in the substantive content of the Clause itself.[13]

C. Opposition to Suicide and Assisted Suicide Is Deeply Rooted In This Nation's History And Tradition

This Court has established the principles to be used by the Judiciary when identifying "rights that have little or no textual support in the constitutional language." *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986) (further citation omitted).

> In *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937), it was said that this category includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion by Powell, J.), where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition."

Bowers, 478 U.S. at 191-192 (citations omitted).

In approaching an historical analysis to determine whether a particular practice has been accepted by our people,

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[13] The States stand as the primary guardians of individual interests in life and liberty. Herein, the States are seeking to protect both individual interests, and their own institutional interests, in life. It is well-settled that individual interests are not afforded any less protection simply because the government, rather than the individual, is defending them. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 n.10 (1990).

it is important to remember that it is *this* Nation's history and tradition which is dispositive. *Cf. Bowers*, 478 U.S. at 191-194. An analysis, such as that utilized by the Ninth Circuit in *Compassion in Dying II*, which centers primarily on "ancient attitudes" having little, if any, relevance to America's historical and traditional treatment of suicide and assisted suicide cannot establish that such practices have been accepted by this Nation.[14]

Opposition to suicide is deeply rooted in *this* Nation's history and tradition. "At common law suicide was a felony, punished by forfeiture of property to the king and ignominious burial. Essentially, suicide was considered a form of murder." *In re Joseph G.*, 34 Cal.3d 429, 433, 194 Cal.Rptr. 163, 165 (1983) (citations omitted). While no State has a statute imposing criminal penalties for a successful suicide,

> abolition of such "punishments" as ignominious burial for suicide and then the decriminalization of both suicide and attempted suicide did not come about because suicide was deemed a "human right" or even because it was no longer considered reprehensible. These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those who committed or

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[14] "[T]he primary and most reliable indication of [a national] consensus . . . [is] the pattern of enacted laws." *Stanford v. Kentucky*, 492 U.S. 361, 373 (1989). All but disregarding the statutes of the overwhelming majority of States which seek to prevent suicide and prohibit assisted suicide, and relying instead on public opinion polls and surveys, the Ninth Circuit found "growing popular support for permitting doctors to provide assistance to terminally ill patients who wish to hasten their deaths. [footnote omitted]" *Compassion in Dying II*, 79 F.3d at 810. Such polls and surveys simply have no place in substantive due process adjudication. Rather, "[a] revised national consensus so broad, so clear, and so enduring as to justify a permanent prohibition upon all units of democratic government must appear in the operative acts (laws and the application of laws) that the people have approved." *Stanford v. Kentucky*, 492 U.S. 361, 377 (1989) (Scalia, J.).

attempted to commit the act were thought to be prompted by mental illness.[15]

In the United States, suicide continues " 'to be considered an expression of mental illness.' "[16] Indeed, the New York State Task Force on Life and the Law found that "[s]tudies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death."[17] "[A]ll states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) (footnotes omitted), *cert. denied*, 115 S.Ct. 1795 (1995). Simply stated, as Justice Scalia pointed out in his concurring opinion in *Cruzan*, " 'there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.' "[18]

Logically, if there is no liberty interest to commit suicide, there can be no liberty interest in receiving the assistance of another to do so. *People v. Kevorkian*, 447 Mich. 436, 468 n.35, 527 N.W.2d 714, 726 n.35 (1994), *cert. denied*, 115 S.Ct. 1795 (1995). However, an independent analysis of

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[15] Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Report, No. 3, 32 (1993) (footnote omitted). See also *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 294-295 (1990) (Scalia, J., concurring).

[16] *In re Joseph G.*, 34 Cal.3d 429, 433, 194 Cal.Rptr. 163, 165 (1983) (citation omitted). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1624, 4 Cal.Rptr.2d 59, 64 (1992).

[17] New York State Task Force Report, *When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context* (hereinafter "*When Death is Sought*") (May 1994) at 11.

[18] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 295 (1990) (Scalia, J., concurring) (citation omitted). *See also* Thomas J. Marzen, *et al.*, *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 100 (1985) (reaching identical conclusion); and *When Death is Sought*, at 54-63 and 67-75.

the issue provides even more evidence that no such derivative interest exists. At common law, a person who assisted another to commit suicide was guilty of murder. *In re Joseph G.*, 34 Cal.3d 429, 434, 194 Cal.Rptr. 163, 165 (1983). "At the time the Fourteenth Amendment was ratified, at least twenty-one of the thirty-seven existing states (including eighteen of the thirty ratifying states) proscribed assisted suicide either by statute or as a common-law offense." *People v. Kevorkian*, 447 Mich. 436, 478, 527 N.W.2d 714, 731 (1994) (citation omitted), *cert. denied*, 115 S.Ct. 1795 (1995).

Today, while a few states continue to classify assisted suicide as murder or manslaughter, "the predominant statutory scheme . . . is to create a sui generis crime of aiding and abetting suicide." *In re Joseph G.*, 34 Cal.3d 429, 434, 194 Cal.Rptr. 163, 165 (1983). The overwhelming majority of States, Puerto Rico and the Virgin Islands, impose criminal penalties on one who assists another to commit suicide.[19]

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[19] The following States, plus Puerto Rico and the Virgin Islands, expressly prohibit assisted suicide by statute: Alaska Stat., § 11.41.120(a)(2) (Michie 1989); Ariz. Rev. Stat. Ann., § 13-1103(A)(3) (West Supp. 1995); Ark. Stat. Ann., § 5-10-104(a)(2) (Michie 1993); Cal. Pen. Code, § 401 (West 1988); Colo. Rev. Stat., § 18-3-104(1)(b) (Supp. 1995); Conn. Gen. Stat. Ann., § 53a-56(a)(2) (West 1994); Del. Code Ann., tit. 11, § 645 (1995); Fla. Stat. Ann., § 782.08 (West 1992); Ga. Code Ann. § 16-5-5(b) (1996); Ill. Comp. Stat. Ann., ch. 720, 5/12-31(a)(2) (Smith-Hurd Supp. 1996); Ind. Stat. Ann., § 35-42-1-2.5(b) (West Supp. 1996); Iowa Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann., § 21-3406 (1995); Ky. Rev. Stat. Ann., § 216.302 (Michie 1995); La. Rev. Stat. Ann., § 14:32.12 (West Supp. 1996); Me. Rev. Stat. Ann., tit. 17-A, § 204 (West 1983); Minn. Stat. Ann., § 609.215 (West 1987 and Supp. 1996); Miss. Code Ann., § 97-3-49 (1994); Mo. Ann. Stat., § 565.023(1)(2) (West Supp. 1996); Mont. Code Ann., § 45-5-105 (1995); Neb. Rev. Stat. Ann., § 28-307 (Michie 1995); N.H. Rev. Stat. Ann., § 630:4 (1996); N.J. Stat. Ann., § 2C:11-6 (West 1995); N.M. Stat. Ann., § 30-2-4 (Michie 1994); N.Y. Penal Law, §§ 120.30, 125.15(3) (McKinney 1987); N.D. Cent. Code, § 12.1-16-04 (Supp. 1995); Okla. Stat. Ann., tit. 21, §§ 813, 814, 815 (West 1983); Pa. Cons. Stat. Ann., tit. 18, § 2505(b) (West 1983); P.R. Laws Ann., tit. 33, § 4009; R.I. Pub. Act 96-133, *to be codified as* R.I. Gen. Stat., tit.

Against this background, the claim that assisted suicide is so "deeply rooted in this Nation's history and tradition" that it is entitled to constitutional protection is entirely devoid of merit.[20]

D. Suicide And Assisted Suicide Are Not Implicit In The Concept Of Ordered Liberty Such That Neither Liberty Nor Justice Would Exist If They Were Sacrificed

"Ordered liberty" is not absolute liberty.[21] Rather, it is the liberty of an individual to pursue her lawful goals, without

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11, ch. 60; S.D. Codified Laws Ann., § 22-16-37 (Michie 1988); Tenn. Code Ann., § 39-13-216 (Supp. 1995); Tex. Penal Code Ann., § 22.08 (West 1994); V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060 (West 1988); and Wis. Stat. Ann., § 940.12 (West 1996). *See also* Or. Rev. Stat. § 163.125(1)(b) (1993) (prohibiting assisted suicide generally), *but see* Or. Rev. Stat. § 127.800 *et seq.* (1996) (permitting physician-assisted suicide in certain circumstances). The following states impose criminal penalties by case law for assisting a suicide: *Commonwealth v. Mink*, 123 Mass. 422, 428-429 (1877); *People v. Kevorkian*, 447 Mich. 436, 493-497, 527 N.W.2d 714, 738-739 (1994), *cert. denied*, 115 S.Ct. 1795 (1995); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); *State v. Jones*, 86 S.C. 17, 22, 47, 67 S.E. 160, 162, 165 (1910); and *State v. Willis*, 255 N.C. 473, 477, 121 S.E.2d 854, 856-857 (1961).

[20] *Cf. Bowers v. Hardwick*, 478 U.S. 186, 192-194 (1986). *See also Jackman v. Rosenbaum Co.*, 260 U.S. 22, 31 (1922) ("The Fourteenth Amendment, itself a historical product, did not destroy history for the States and substitute mechanical compartments of law all exactly alike. If a thing has been practised for two hundred years by common consent, it will need a strong case for the Fourteenth Amendment to affect it, . . . ").

[21] Almost a century ago, the Court reaffirmed this understanding of liberty when it stated that:

> [T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy. Real liberty for all could not exist under the operation of a principle which recognizes the right of each individual person to use his own, whether in respect of his person or his property, regardless of the injury that may be done to others. This court has more than once recognized it as a fundamental principle that "persons and property are subjected to all kinds of restraints and burdens in order to secure the general comfort, health, and prosperity of the state; of the perfect right of the legislature to do which no question ever was, or upon acknowledged general principles ever can be, made, so far as natural persons are concerned."

Jacobson v. Massachusetts, 197 U.S. 11, 26 (1905) (citations omitted).

unreasonable state interference, in light of "the demands of organized society." *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting). "Ordered liberty" is not founded, as the Ninth Circuit's opinion was, on a concept of autonomous self-determinism. Rather, it is founded on a firm understanding of the "traditions and conscience of our people . . . " *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (citations omitted). As the second Justice Harlan observed in *Griswold v. Connecticut*, 381 U.S. 479, 501 (1965) (Harlan, J., concurring in judgment):

> Judicial restraint . . . will be achieved in this area, as in other constitutional areas, only by continual insistence upon respect for the teachings of history, solid recognition of the basic values that underlie our society, and wise appreciation of the great roles that the doctrines of federalism and separation of powers have played in establishing and preserving American freedoms. (citation omitted)[22]

With these principles in mind, this Court must now determine whether suicide and assisted suicide are "implicit in the

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[22] *See also Ex parte Grossman*, 267 U.S. 87, 108-109 (1925) ("The language of the constitution cannot be interpreted safely except by reference to the common law and to British institutions as they were when the instrument was framed and adopted.").

concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937) (citation omitted). In *Compassion in Dying II*, the Ninth Circuit failed to even apply this standard and, instead, simply declared:

> That [this] language . . . has never been applied literally. It would be difficult, if not impossible, for any fundamental right or liberty interest to meet such a standard. One could hardly argue for example that neither liberty nor justice would survive if contraceptives were banned, as they were for most of our history. Nor indubitably, would even the most vigorous proponent of abortion rights argue that neither liberty nor justice existed in this nation prior to *Roe*.

Compassion in Dying II, 79 F.3d at 813 n.64 (insert added).

Application of the *Palko* standard is neither difficult nor impossible and, contrary to the Ninth Circuit's view, this Court has concluded that certain fundamental rights and interests plainly meet that standard. Examples of this can be found in *Palko* itself where, discussing "the privileges and immunities that have been . . . brought within the Fourteenth Amendment by a process of absorption," the Court cited "freedom of thought, and speech," and noted that this freedom "is the matrix, the indispensable condition, of nearly every other form of freedom."[23] *Palko*, 302 U.S. 326-327. "[C]ondemnation only after trial", and a defendant's right to counsel in a state-court capital case were other examples of fundamental liberty interests cited by the Court in *Palko*. *Id.* at 327 (citations omitted). As in *Palko*, the question herein (which the Ninth Circuit never reached) is simply this:

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[23] Twelve years earlier, in *Gitlow v. New York*, 268 U.S. 652, 666 (1925), the Court stated that: "For present purposes, we may and do assume that freedom of speech and of the press – which are protected by the First Amendment from abridgment by Congress – are among the fundamental personal rights and 'liberties' protected by the due process clause of the Fourteenth Amendment from impairment by the States."

> Is [Washington's absolute prohibition of assisted suicide] so . . . shocking that our policy will not endure it? Does it violate those "fundamental principles of liberty and justice which lie at the base of all our civil and political institutions"?

Id. at 328 (citation omitted, insert added).

Indeed, can it truly be said that "[j]ustice . . . would . . . perish" (*Id.*, at 326) if the States continue to prevent their citizens from committing suicide and, at the same time, continue to prohibit one person from assisting another to commit suicide? Plainly, the answer to all of these questions is "no." Of "the basic values that underlie our society," (*Griswold*, 381 U.S. at 501 (Harlan, J., concurring in judgment)), certainly the most important is our fundamental respect for human life. State policies which further that most basic societal value can hardly be said to imperil either justice or liberty.

Rather than applying the *Palko* standard consistent with the precedents of this Court, the Ninth Circuit relied on *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), and *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), to support its discovery of new liberty interests to commit suicide and assisted suicide. That reliance was entirely misplaced.

In *Casey*, the Court was not called upon to decide whether some newly asserted liberty interest to choose an abortion was entitled to constitutional protection. Rather, the primary question presented in *Casey* was whether the fundamental holding of *Roe v. Wade*, 410 U.S. 113 (1973), should be overruled. *Casey*, 505 U.S. at 844-846. Thus, the Court had no reason to discuss, and did not discuss, the well-established principles for construing the substantive content of the Due Process Clause. The Ninth Circuit's extensive reliance on *Casey*, and its apparent belief that *Casey* has modified, *sub silentio*, long-standing principles for construing the substantive content of the Due Process Clause, was particularly surprising since, in the same opinion, the Ninth Circuit rejected similar arguments regarding the effect of the Court's decision in *Reno v. Flores* as to whether all liberty interests

other than fundamental rights would be subjected to rational-basis review or balancing.[24]

In declaring the existence of new liberty interests to commit suicide and assisted suicide, the Ninth Circuit found the following three sentences from *Casey* to be almost controlling on the issue before it:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.[25]

Contrary to the Ninth Circuit's reasoning, these three sentences taken from *Casey* – broad generalities on the nature

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[24] In attempting to distinguish *Reno v. Flores*, the Ninth Circuit stated that:

> The Court did not, as the dissent implies, purport to establish a new classification system under which all liberty interests other than fundamental rights would be subject to rational basis review. Nor did *Flores* purport to overrule, or even hint at any desire to modify, the Court's ninety-year-old practice of using a balancing test in liberty interest cases that raise important issues of the type before us. In fact, *Flores* did not mention *Cruzan*, *Youngberg*, *Mills*, *Jacobson*, or any other balancing case.

Compassion in Dying II, 79 F.3d at 804 (footnote omitted). These same arguments are equally applicable to the Ninth Circuit's apparent belief that *Casey* has overruled or modified, *sub silentio*, long-standing principles for construing the substantive content of the Due Process Clause.

[25] *Compassion in Dying II*, 79 F.3d at 813, *quoting Casey*, 505 U.S. at 851. *See also Id.* (Ninth Circuit agreeing with district court that *Casey* is "highly instructive and almost prescriptive for determining what liberty interest may inhere in a terminally ill person's choice to commit suicide. [citation and internal quotes omitted]").

of the liberty protected by the Fourteenth Amendment – did not establish a new standard for construing the substantive content of the Due Process Clause. If the Court in *Casey* had intended to eliminate the long-standing principles which govern substantive due process adjudication, plainly it would have said so. Furthermore, when taken out of context, "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" has almost limitless application. Likewise, many activities which plainly are not entitled to constitutional protection can nevertheless be characterized as "intimate", "personal" or involving "choices central to personal dignity and autonomy." When taken out of context and fashioned into a new standard for substantive due process adjudication, these three sentences are entirely inconsistent with accepted understandings of "ordered liberty." Such a new standard would virtually eliminate the "guideposts for responsible decisionmaking in this unchartered area [which] are [already] scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992) (inserts added).

The Ninth Circuit's reliance on *Casey* was also predicated on the mistaken notion that simply because a decision may involve "choices central to personal dignity and autonomy," one is free to do whatever one wants with one's body. This is not the "ordered liberty" discussed by the Court in *Palko* and the cases which followed it. Rather, this is precisely the sort of "unlimited right to do with one's body as one pleases" which this Court has consistently and soundly rejected. *See Roe v. Wade*, 410 U.S. 113, 154 (1973), and cases cited therein; *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); and *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 (1973), *citing*, *inter alia*, constitutionally unchallenged laws against suicide.

The Ninth Circuit's reliance on *Casey* also ignores the fundamental differences between abortion, suicide and assisted suicide. This Court has held that abortion does not extinguish the life of a "person" in the context of the

Fourteenth Amendment.[26] Certainly, it cannot be denied that suicide does. Under *Roe*, abortion concerns the choice of a woman, the decision-maker, to live her life without the dangers and unwanted conditions associated with pregnancy.[27] Suicide, on the other hand, is about death, *i.e.*, the death of the decision-maker. Finally, the States' treatment of abortion and assisted suicide has been markedly different. In *Roe*, the Court observed that "[i]n the past several years, . . . a trend toward liberalization of abortion statutes ha[d] resulted in adoption, by about one-third of the States, of less stringent laws, . . . " *Roe v. Wade*, 410 U.S. 113, 139-140 (1973). No such trend exists with respect to assisted suicide. *See* ns.6 and 19, *supra*.

In summary, as Justice O'Connor observed in *Casey*, "[a]bortion is a unique act" and "the liberty interest of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. It is a fundamental error to seek to discover new constitutional rights to commit suicide and assisted suicide by analogizing to the unique abortion rights jurisprudence. There is simply no indication in *Casey*, or the precedent from which it evolved, of an intention to expand the liberty interests previously identified by this Court in the manner utilized by the Ninth Circuit.

Nor does this Court's decision in *Cruzan* support the Ninth Circuit's discovery of new liberty interests to commit suicide and assisted suicide. In *Cruzan*, this Court stated

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[26] *Roe v. Wade*, 410 U.S. 113, 158-159 (1973). While, under *Roe*, an unborn fetus is not yet a "person" as that word is used in the Fourteenth Amendment, its proximity to that status after viability so strengthens the State's interest in preserving and protecting fetal life that nontherapeutic abortions can be absolutely prohibited at that stage of a woman's pregnancy. *See Roe*, 410 U.S. at 164-165 and *Casey*, 505 U.S. at 846, 860, 869, 870, and 879.

[27] *Roe v. Wade*, 410 U.S. 113, 153 (1973) (listing factors a woman and her physician would necessarily consider when considering an abortion).

that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Cruzan*, 497 U.S. at 278. Later in the opinion, the Court stated that "*for purposes of this case*, we *assume* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Cruzan*, 497 U.S. at 279 (emphasis added). Careful examination of this portion of the *Cruzan* opinion reveals two critical points. First, the Court *assumed*, but did not expressly hold, that there is a constitutionally protected interest to refuse life-sustaining medical treatment. Second, this assumption was expressly limited to the *Cruzan* case. Notwithstanding this clear language, the Ninth Circuit read *Cruzan* as "necessarily recogniz[ing] a liberty interest in hastening one's own death." *Compassion in Dying II*, 79 F.3d at 816 (footnote omitted, insert added). Such a reading of *Cruzan* assumes far too much.[28] It is error to attempt to construe *Cruzan's* limited assumption of an interest to refuse medical treatment as acceptance by this Court of a far broader interest to commit suicide and, broader still, assisted suicide. Indeed, the error of such an attempt is plainly evidenced by the majority's recognition in *Cruzan* that, even in the face of a right to refuse medical treatment, the States may properly assert important interests in the protection and preservation of human life, and in the prevention of both suicide and assisted suicide. *Cruzan*, 497 U.S. at 280-282. In summary, suicide and assisted suicide are so significantly different from the refusal of unwanted medical treatment, and its legal underpinnings, that an interest

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[28] The Ninth Circuit's broad reading of *Cruzan* is also inconsistent with this Court's clear admonition in *Cruzan* itself that "in deciding a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject." *Cruzan*, 497 U.S. at 277-278 (citation and internal quotes omitted, insert and omission original).

in committing suicide or assisted suicide simply cannot be inferred from *Cruzan*.[29]

E. The New Liberty Interests In Suicide And Assisted Suicide Discovered By The Ninth Circuit Cannot Be Limited To Terminally-Ill, Mentally Competent Adults

If personal autonomy and the right to refuse unwanted medical treatment are the roots for these newly discovered liberty interests to commit suicide and assisted suicide, any purported limitation of these new interests to just terminally ill, mentally competent adults is plainly insupportable.

In this regard, Professor Yale Kamisar has observed:

> If personal autonomy and the termination of suffering are the key factors fueling the right to assisted suicide, why exclude those with non-terminal illnesses or disabilities who might have to endure greater "unbearable suffering" for much longer periods of time than those who are likely to die in the near future? Why does not a person who must continue to live what she considers an unendurable existence for ten or twenty more years have an equal – or even greater – claim on the liberty interest in assisted suicide than those with terminal conditions?

Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in Euthanasia Examined, 225, 234 (John Keown, ed. 1995) (Cambridge University Press) (footnote omitted).

While the Ninth Circuit, at least in the case below, purported to limit suicide and assisted suicide to just the terminally ill,

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[29] Unlike suicide, "[t]he right to refuse medical treatment meets the 'ordered liberty' and the 'historical underpinnings' tests because it is rooted in the common-law doctrine of informed consent, which embodies the notion of bodily integrity." *People v. Kevorkian*, 447 Mich. 436, 480 n.59, 527 N.W.2d 714, 732 n.59 (1994), *cert. denied*, 115 S.Ct. 1795 (1995).

> Why stop there? If a competent person comes to the unhappy conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not "qualify" under somebody else's standards? Isn't *this* an arbitrary limitation of self-determinism and personal autonomy?

Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Report, No. 3, 32, 37 (1993) (emphasis original).

Indeed, as the Michigan Supreme Court recently observed:

> [B]ecause all persons possess a basic right to personal autonomy, regardless of their physical or mental condition, there would be no principled basis for restricting a right to commit suicide to the terminally ill. The inevitability of death adds nothing to the constitutional analysis.

People v. Kevorkian, 447 Mich. 436, 470 n.41, 527 N.W.2d 714, 727-728 n.41 (1994), *cert. denied*, 115 S.Ct. 1795 (1995).

Nor do the right-to-refuse treatment cases provide any support for such a limitation. First, there is wide disagreement among the States as to the definition of "terminal illness."[30] Second, the right-to-refuse medical treatment has not been limited to just the terminally ill.[31] Finally, even if these newly discovered liberty interests in suicide and assisted suicide are initially limited to just the

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[30] *See* Alan Meisel, *The Right to Die*, Vol 2, § 11.9, 96-101 (2d ed. 1995). *See also* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, 799, 814-819 (1994); Yale Kamisar, *Physician-Assisted Suicide: The Last Bridge to Active Voluntary Euthanasia*, in Euthanasia Examined, 225, 234 (John Keown, ed. 1995) (Cambridge University Press).

[31] *See Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 277 (1990) ("As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.").

terminally ill, it is far from clear whether the Ninth Circuit intends that limitation to endure for long. In this regard, the Ninth Circuit stated that:

> Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness.

Compassion in Dying II, 79 F.3d at 816 (citation omitted).

If the decision below is affirmed, the next question to be decided by the courts will be whether those who are neither terminally ill nor mentally competent can likewise exercise these new liberty interests to commit suicide and assisted suicide. The question of whether the States may prohibit active voluntary euthanasia, as opposed to suicide and assisted suicide, will likewise be on the horizon.[32] Thus, the decision below does not simply push the States down the so-called "slippery slope" – it hurls them over the precipice into a bottomless pit of constitutional litigation where they will spend decades litigating the parameters of these newly discovered liberty interests in suicide and assisted suicide.

II. RELEVANT STATE INTERESTS CLEARLY OUTWEIGH ASSERTED INTERESTS IN SUICIDE AND ASSISTED SUICIDE

Only if this Court finds protected liberty interests in suicide and assisted suicide, does it then become necessary to

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[32] *Compassion in Dying II*, 79 F.3d at 831-832 ("We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them. [footnote omitted] The question whether that type of physician conduct may be constitutionally prohibited must be answered directly in future cases, and not in this one. We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life.").

balance those interests against countervailing state interests.[33] In the event of such a finding, the wide range of circumstances within which these newly discovered interests could be exercised implicate several important state interests, including, but not limited to: (1) the protection and preservation of human life;[34] (2) the prevention of suicide;[35] (3) preventing the fraud, errors and abuse which would accompany acceptance of suicide and assisted suicide;[36] (4) maintaining the ethical integrity of the medical profession;[37] (5) protecting the poor and minorities from

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[33] *Cruzan*, 497 U.S. at 261. *Cf. Quill*, 80 F.3d 716, 723-725 (rejecting Fourteenth Amendment assisted suicide liberty interest claim and thus no balancing required); *People v. Kevorkian*, 447 Mich. 436, 463-481, 527 N.W.2d 714, 724-733 (1994) (reaching same conclusion and thus no balancing required), *cert. denied*, 115 S.Ct. 1795 (1995).

[34] *Cruzan*, 497 U.S. at 280.

[35] "Suicide is the eighth leading cause of death in the United States." *When Death is Sought*, at 9 (footnote omitted). "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." *Id.*, at 11. Furthermore, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.*, at 13 (footnote omitted).

[36] *Cruzan*, 497 U.S. at 281 ("[E]ven where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations. [citation omitted, internal quotes omitted]"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr. 59, 64 (1992) ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."), and *Donaldson*, 2 Cal.App.4th at 1624 ("Third parties, even family members, do not always act to protect the person whose life will end.").

[37] *Cf. Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 434 (1982) (important state interest in "maintaining and assuring the professional conduct of professional attorneys it licenses").

exploitation;[38] (6) protecting handicapped persons from societal indifference;[39] and (7) protecting innocent third parties.[40]

While the Ninth Circuit acknowledged, at least to some extent, some of these interests, its application of the balancing test was fundamentally flawed by the improper insertion of quality-of-life considerations which it used to discount the strength of various important state interests.[41] Such quality-of-life considerations are directly contrary to this Court's holding in *Cruzan* that "a State may properly decline to make

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See also Donaldson v. Lungren, 2 Cal.App.4th 1614, 1620, 4 Cal.Rptr.2d 59, 62 (1992) (recognizing state interest in maintaining the ethical integrity of the medical profession). In reaffirming its long-standing opposition to physician-assisted suicide, the American Medical Association has declared that physician-assisted suicide "threatens the very core of the medical profession's ethical integrity" and is "fundamentally inconsistent with the physician's professional role." American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics Reports*, Vol. V, No. 2 (July 1994), Report 59, *Physician-Assisted Suicide*, 269 and 274, respectively.

[38] *Quill*, 80 F.3d at 730, *citing Compassion in Dying I*, 49 F.3d 586, 592 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[39] *Quill*, 80 F.3d at 730, *citing Compassion in Dying I*, 49 F.3d 586, 592-593 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[40] *Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 331 F.2d 1000, 1008 (1964), *cert. denied*, 377 U.S. 978 (1964). *See also Bartling v. Superior Court*, 163 Cal.App.3d 186, 195 n.6, 209 Cal.Rptr. 220, 225 n.6 (1984).

[41] *Compassion in Dying II*, 79 F.3d at 817 (strength of the state's important interest in the preservation of human life "is dependent on relevant circumstances, including the medical condition and the wishes of the person whose life is at stake."); *Id.*, at 820 (state interest in preventing suicide, "like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die. [footnote omitted]"); *Id.*, at 825 (state's interest in preventing involvement of third persons at a minimum "when the assistance is provided by or under the supervision or direction of a doctor and the recipient is a terminally ill patient."); and *Id.*, at 827 (state's interest in protecting innocent third parties "is of almost negligible weight when the patient is terminally ill and his death is imminent and inevitable.").

judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282.

Moreover, the dangers inherent in using such quality-of-life considerations are well-recognized. "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 422 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). An analysis such as that utilized by the Ninth Circuit also disregards the irrefutable principle that all lives, from beginning to end and irrespective of physical or mental condition, are under the full protection of the law. *See Blackburn v. State*, 23 Ohio St. 146, 163 (1872). When properly weighed, without the insertion of improper quality-of-life considerations, the States' interests, individually and collectively, clearly outweigh any individual interests in committing suicide and assisted suicide.

III. THE DECISION BELOW SHOULD BE REVERSED IN ORDER TO REAFFIRM THE ESSENTIAL ROLE OF THE STATES IN OUR FEDERAL SYSTEM OF GOVERNMENT AND THE POWER OF THE PEOPLE TO DIRECTLY GOVERN THEIR OWN AFFAIRS

As the States grapple with the difficult questions presented by the ever-increasing ability of medical technology to prolong life, the corresponding need to allow the States to serve as laboratories for change becomes paramount. Indeed, as this Court has recognized, "[t]he science of government . . . is the science of experiment, . . . " *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985) (citation and internal quotes omitted). A decision affirming the Ninth Circuit's opinion in *Compassion in Dying II* will effectively extinguish the power of the States to continue to serve as laboratories for change on an issue that arguably will affect more lives than any issue the States will face in the foreseeable future. *See*

New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting). It will also "invite[] an unelected federal judiciary to make decisions about which state policies it favors and which ones it dislikes." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985). At the same time, it will "relegate the States to precisely the trivial role that opponents of the Constitution feared they would occupy."[42] *Garcia*, 469 U.S. at 575 (Powell, J., dissenting) (footnote omitted).

> That a question is important does not mean that it is constitutional. The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary.

Compassion in Dying II, 79 F.3d 790, 858 (9th Cir. 1996) (Kleinfeld, C.J., dissenting).

CONCLUSION

For all the foregoing reasons, the judgment of the United States Court of Appeals for the Ninth Circuit in No. 96-110 should be reversed.

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[42] "If the several States in the Union are to become one entire Nation, under one Legislature, the Powers of which shall extend to every Subject of Legislation, and its Laws be supreme & controul the whole, the Idea of Sovereignty in these States must be lost." Samuel Adams, Letter to Richard Henry Lee, 3 Dec. 1787, in *The Writings of Samuel Adams* 4:324 (Harry A. Cushing ed. 1968).

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No. 96-110

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,
Petitioners,
v.
HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEW YORK CATHOLIC CONFERENCE; WASHINGTON STATE CATHOLIC CONFERENCE; OREGON CATHOLIC CONFERENCE; CALIFORNIA CATHOLIC CONFERENCE; MICHIGAN CATHOLIC CONFERENCE; CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; NATIONAL ASSOCIATION OF EVANGELICALS; THE LUTHERAN CHURCH-MISSOURI SYNOD; WISCONSIN EVANGELICAL LUTHERAN SYNOD-LUTHERANS FOR LIFE; THE EVANGELICAL COVENANT CHURCH; AND THE AMERICAN MUSLIM COUNCIL IN SUPPORT OF PETITIONERS STATE OF WASHINGTON, ET AL.

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INTEREST OF *AMICI*

This Court has agreed to review a decision that draws a startling and unprecedented conclusion—that the Due Process Clause confers a right to obtain from one's physician the means of committing suicide. This remarkable and erroneous conclusion obliterates a most basic tenet of American law—that the State may prohibit conduct that facilitates the killing of another person. For this reason, representatives of diverse religious communities unite here across denominational lines as *amici curiae* to demonstrate to this Court why the lower court was wrong. Our Constitution does not create a right to have one's life taken, much less a right to dispense lethal drugs to facilitate the killing of others. Individual statements of interest follow.

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Roman Catholic Bishops in the United States. The Catholic Bishops of New York, Washington, Oregon, California, and Michigan are, in addition, members of the State Catholic Conferences of those respective states. The Conferences are vehicles through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. Roman Catholicism is the largest religious denomination in the United States, with over 60 million members in this country. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. Each Conference has been active in supporting state laws that protect persons from assisted suicide.

The Christian Life Commission is the moral concerns and public policy agency for the Southern Baptist Convention, the nation's largest Protestant denomination, with over 15.2 million members in over 38,000 autonomous

local churches. The Commission is charged with addressing public policies affecting the sanctity of human life.

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 42,500 churches from 75 denominations, and 300 parachurch ministries. NAE has joined in this and many other *amicus* briefs in the defense of human rights, including the right to life.

The Lutheran Church-Missouri Synod is the second-largest Lutheran denomination in the United States. It has about 6,000 member congregations and about 2.6 million individual members. In 1995, as a result of their deeply held religious beliefs on the sanctity of life, the congregations of the Synod passed a resolution expressing the Synod's objection "to medical personnel having any part in actively inducing death, even at the patient's request." The Synod resolved "to speak against any attempt to legalize physician-assisted suicide."

The Wisconsin Evangelical Lutheran Synod-Lutherans for Life is a para-synod organization in fellowship with the 400,000-member Wisconsin Evangelical Lutheran Synod ("WELS") and the 10,000-member Evangelical Lutheran Synod. WELS-Lutherans for Life is a specialized ministry seeking to make known God's will on life and to provide assistance to others on life issues. God's will concerning euthanasia and suicide is clear, recognizing that God acknowledges the absolute value of human life despite its varying or diminished quality. WELS-Lutherans for Life stands by the conviction that it is contrary to the will of God to take one's own life or to assist in doing so.

The Evangelical Covenant Church ("ECC") is a Protestant denomination with 92,000 members in 600 churches throughout the United States It operates a university, two hospitals, twelve continuing care and retirement com-

munities, and twelve nursing homes as a Christian ministry. ECC has adopted an ethical guideline on death and euthanasia. The guideline affirms the ECC's commitment to provide "the best palliative measures we can to relieve the pain, discomfort and suffering of our patients. . . . We do not act in any way intentionally to cause, assist, or accelerate the death of patients."

The American Muslim Council ("AMC") is a nationally recognized organization representing the interests of the American Muslim community. AMC is a committed advocate of human rights. It participates in interfaith and multiethnic dialogue with the hope of promoting an environment in which tolerance and justice will thrive. AMC's opposition to assisted suicide is rooted in Islamic belief, which strongly affirms the sanctity of human life.

Through their counsel, the parties have consented to the appearance of these *amici*.

SUMMARY OF ARGUMENT

Americans are a people who esteem personal freedom. But personal freedom is lived and experienced in a human community. To live together in a community requires accommodation, compromise, and even limitations on one's choices in order to protect the common good. We are not a nation in which each person is a law unto himself or herself, but a nation of ordered liberty.

In preserving those freedoms essential to ordered liberty, this Court has insisted that the judiciary give special attention to the constitutional text, to history and tradition, and to the specificity of a claim in evaluating whether a personal demand also finds expression in the Due Process Clause. The claims advanced in the court below fail these basic tests.

In this case, the Ninth Circuit read the Due Process Clause to hold that persons who are terminally ill have

a liberty interest in having someone else provide the means of taking their own lives. While the courts have often struggled with the scope and meaning of the word "liberty," it is plain that life is necessary to the exercise of any other right or liberty. A demand for assistance in killing oneself has never received protection under the constitutional guarantee of liberty. Indeed, the text of the Due Process Clause would be emptied of meaning were it read as protecting a right to be *deprived* of life and liberty.

Moreover, the court below disregarded a basic tenet of the common law, that one person may not facilitate the killing of another person. The Washington statute at issue here is such a law. It is quite distinct from the law regulating the acceptance or rejection of medical treatment. One is not required to accept every conceivable medical treatment that might preserve life. This case, however, is not about letting people die by terminating treatment, but deliberately and intentionally making people die through affirmative means. Our history and traditions have never permitted the latter.

Absent action by this Court, the decision below would set in motion profound and ominous changes in how our society will care for persons who are old, poor, disabled, and vulnerable. Lifting prohibitions against assisted suicide will have a disproportionate and adverse impact upon the poor, the elderly, minorities, women, and those without access to medical care. These are precisely the people whom our Constitution should protect. This Court is being asked by respondents to alter the fundamental nature of our relationships at the end of our lives, and to do so with no reliable guide as to the consequences. The radical departure from our legal traditions sought below could adversely affect the life and death of every American. This Court should reverse.

ARGUMENT

An ardent champion of personal freedom, Justice William O. Douglas, understood that living together in a community requires accommodation, compromise, and limitations on one's choices in order to protect the common good. In his concurring opinion in *Roe v. Wade*, 410 U.S. 113 (1973), he wrote that liberty included "autonomous control over the development of one's intellect, interests, tastes and personality." *Id.* at 211. Yet such freedom of thought and belief, which Justice Douglas said was "absolute, permitting of no exceptions," is internal to the person. Personal choices exhibited in *conduct* are subject to restraint for the sake of the common good and civic peace and order. Some conduct, which might at first glance appear exclusively personal, is subject even to outright prohibition for these reasons. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905). We are a nation not of unbridled and autonomous liberties, but of ordered liberty.

While accommodation and compromise are first and foremost the task of our democratic and legislative process, this Court has a role in preserving those personal freedoms that are essential to ordered liberty. Yet the Court's reliance upon principles or values that cannot fairly be read into the Constitution "usurp the people's authority, for such decisions represent choices that the people have never made and that they cannot disavow through corrective legislation." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 787 (1986) (White, J., dissenting). The need for restraint is particularly essential in interpreting a concept as potentially open-ended as "liberty":

> The Judiciary, including this Court, is the most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or even the design of the Constitution. Realizing that the present construction of the Due Process Clause represents a major judicial gloss on its terms, as well as on the anticipation of the Framers . . ., the Court should be extremely reluctant to breathe still further substantive content into the Due Process Clause so as to strike down legislation adopted by a State or city to promote its welfare.

Moore v. East Cleveland, 431 U.S. 494, 544 (1977) (White, J., dissenting).

The claimed right in the case at bar is a demand for the affirmative assistance of another to end one's life. Although this demand has been called by various names, what respondents have asked this Court to create is a "right" to assistance in committing suicide. In holding that there is such a right implicit in the Due Process Clause, the lower court disregarded this Court's decisions on substantive due process and acted in derogation of the common good.

I. THE CONSTITUTION DOES NOT CREATE OR PROTECT A RIGHT TO ASSISTED SUICIDE.

A. Assisted Suicide Does Not Satisfy Any of the Criteria This Court Has Established For Identifying Interests Subject to the Protection of Substantive Due Process.

1. *This Court Has Insisted Upon a Rigorous Test for Substantive Due Process Claims.*

Three methodological principles for identifying interests entitled to substantive due process protection have emerged from this Court's decisions, ensuring judicial restraint and preventing this Court's substantive due process jurisprudence from becoming simply a product of "the predilections of those who happen at the time to be Members of [the] Court." *Moore v. East Cleveland*, 431 U.S. at 502. First, no interest can be protected under the substantive component of the Due Process Clause if recognition of that interest conflicts with the text of the Con-

stitution. If it were otherwise, the Due Process Clause would simply be a judicial vehicle for amending the Constitution, in contravention of the exclusive mechanism that the constitutional text itself establishes for amendment.

Second, this Court has identified those interests entitled to substantive due process protection by reference to an objective standard, to wit, those interests which are "deeply rooted in this Nation's history and tradition," *id.* at 503, or which are so "fundamental" as to lie at the very "base of our civil and political institutions" such that "ordered liberty" could scarcely be imagined were they eliminated. *Palko v. Connecticut*, 302 U.S. 319, 325, 328 (1937); *see also Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (due process protects those liberties "so rooted in the traditions and conscience of our people as to be ranked as fundamental"); *Griswold v. Connecticut*, 381 U.S. 479, 501 (1965) (the Court has "continual[ly] insist[ed] upon respect for the teachings of history [and] solid recognition of the basic values that underlie our society") (Harlan, J., concurring in judgment). Thus, history plays more than a merely "useful role," *Compassion in Dying v. Washington*, 79 F.3d 790, 805 (9th Cir. 1996), in deciding questions of substantive due process. Opinion polls (*id.* at 810) and "changing values" (*id.* at 802-3) may influence legislators, but judges are bound by a more enduring standard in matters of constitutional law.[1]

[1] The Ninth Circuit's assessment of public opinion was not only misplaced but wrong. Since 1994, at least seventeen states have rejected legislative proposals to legalize assisted suicide. Alaska, HB 371 (died in House State Affairs Committee, 1996); Arizona, S.B. 1007 (negative vote in Senate Health Committee, Jan. 1996); California, A. 1080 (withdrawn by sponsor in 1995) and A. 1310 (died without a hearing, Jan. 1996); Colorado, H.B. 1308 (tabled by House Committee on Health, Environment, Welfare and Institutions, Feb. 1995) and H.B. 1185 (defeated 7-to-4 in the same committee, Feb. 1996); Connecticut, S.B. 361 (died in committee, April 1995); Maine, L.D. 748 (rejected by House Judiciary Committee 10-to-3 and by full House 105-to-35, June 1996); Maryland, H.B. 933 (rejected by House Environmental Affairs Committee 15-to-4 in 1995) and H.B. 474 (rejected by same committee 16-to-5 in 1996); Massachusetts, H.B. 3173 (died in House Judiciary Committee, May 1995); Michigan, H.B. 4134 (died in committee, 1995); Mississippi, H.B. 1023 (died in House Judiciary Committee, 1996); Nebraska, L.B. 1259 (died in Judiciary Committee, 1996); New Hampshire, H.B. 339 (rejected by House of Representatives 256-to-90, Jan. 1996); New Mexico, S.B. 446 (tabled 6-to-1 by Senate Judiciary Committee, Feb. 1995); New York, S. 1683, S. 5024-A, A. 6333 (died without a hearing in 1995); Vermont, H.B. 335 (died in House Committee on Health and Welfare, 1995); Washington, S.B. 5596 (died in committee, March 1995); Wisconsin, S.B. 90 and A.B. 174 (died in committee).

The voters of Washington have specifically rejected an effort to weaken their State's law against assisted suicide by referendum, as has the State of California. Dennis L. Breo, *MD-Aided Suicide Voted Down; Both Sides Say Debate to Continue*, 266 JAMA 2895 (Nov. 27, 1991). In 1996, Iowa and Rhode Island joined the majority of states that impose criminal penalties on assisted suicide. Iowa S.F. 2066, to be codified at Iowa Code § 707A.2 (Supp. 1996); R.I. Pub. Act 96-133, to be codified at R.I. Gen. Stat. tit. 11, ch. 60.

Opinion polls indicate a divided and ambivalent electorate on this question, *see Legislating Assisted Suicide*, The Washington Post, Apr. 4, 1996, at A18, with opposition to assisted suicide being strongest among the frail, elderly, and terminally ill—precisely those most directly affected by the issue. Harold G. Koenig, *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Arch. Intern. Med. 2240 (Oct. 28, 1996); Ezekiel J. Emanuel, *et al., Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 The Lancet 1805 (June 29, 1996).

That history is the linchpin for deciding what is protected under substantive due process is evident from this Court's decisions. Early in this century, relying upon our nation's historic recognition of the right and duty of parents to direct the upbringing of their children, this Court struck down laws that forbade parents to have their children taught a foreign language, *Meyer v. Nebraska*, 262 U.S. 390 (1923), or to send their children to private schools. *Pierce v. Society of Sisters*, 268 U.S.

510 (1925). In *Griswold v. Connecticut*, this Court relied upon the historic sanctity of the marital relationship to overturn the conviction of a physician for giving a married couple information and advice about contraceptives. 381 U.S. at 486. This Court said that the Connecticut law "operat[ed] directly on an intimate relation of husband and wife," having a "maximum destructive impact" upon that relationship. *Id.* at 482, 485.[2] Justice Goldberg, in concurring, left no doubt that in his view it was the marital or family relationship that the Connecticut law threatened. That law, he wrote, "disrupt[ed] the traditional relation of the family—a relation as old and as fundamental as our entire civilization. . . ." *Id.* at 495-96 (Goldberg, J., concurring).[3]

History was also identified as the operative principle when the Court defined abortion to be a constitutional right. Half of the majority opinion in *Roe v. Wade* is devoted to historical attitudes toward abortion. Based on this review, a majority of the Court concluded that statutes banning abortion were "of relatively recent vintage," deriving from "statutory changes effected, for the most part, in the latter half of the 19th century." 410 U.S. at 129, 140-41. While the Court's historical account in

[2] This Court's concern with the text of the Constitution is also apparent in *Griswold*. The Court relied upon "the zone of privacy created by several constitutional guarantees." 381 U.S. at 485. Among the various guarantees identified by the Court were the fourteenth amendment freedom to educate one's children, *id.* at 482, the first amendment right of association, *id.* at 483, and the third and fourth amendment right to be free of governmental intrusion into the home. *Id.* at 484.

[3] Reliance upon history and tradition has been equally dispositive in identifying rights triggering heightened judical scrutiny under the Equal Protection Clause. In *Loving v. Virginia*, 388 U.S. 1 (1967), for example, in striking down on equal protection and due process grounds a Virginia law that forbade interracial marriages, the Court observed that "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men." 388 U.S. at 12.

Roe is seriously flawed,[4] this Court's extended historical discussion in *Roe* nonetheless underscores its continued reliance upon our Nation's history and traditions to identify interests entitled to substantive due process protection.

Nothing in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), repudiates the historical standard to which *Roe* and earlier cases adhered over the course of nearly a century. Indeed, *Casey* reaffirmed that in its substantive due process decisions this Court looks to "what history teaches are the traditions from which [the Nation] developed as well as the traditions from which it broke." *Casey*, 505 U.S. at 850, *quoting Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds).[5] Legislators can look where they will, but it is our history and traditions that this Court for a century has embraced as the objective criterion that will prevent its substantive due process jurisprudence from lapsing into an expression of the justices' own "personal and private notions." *Griswold v. Connecticut*, 381 U.S. at 493 (Goldberg, J., concurring).[6]

[4] D. Horan & B. Balch, *Roe v. Wade: No Justification in History, Law or Logic*, J. Connery, *The Ancients and the Medievals on Abortion: The Consensus the Court Ignored*, and M. Arbagi, *Roe and the Hippocratic Oath*, in Abortion and the Constitution (eds. D. Horan, E. Grant & P. Cunningham) (Georgetown University Press 1987). As this Court is aware, Christian groups appearing here as amici believe that *Roe* was wrongly decided.

[5] This is not to dispute that constitutional adjudication requires "reasoned judgment." *Casey*, 505 U.S. at 849. Reason, however, does not operate without criteria to guide it. Otherwise, judges would indeed be "free to roam where unguided speculation might take them." *Id.* at 850, *quoting Poe v. Ullman*, 367 U.S. 497, 542 (Harlan, J., dissenting).

[6] The plurality opinion in *Casey* does concern itself with the protection of certain choices it called "intimate" and "personal." 505 U.S. at 851. We do not view this language as setting forth a new test for due process purposes or even signaling a willingness to depart from settled constitutional law. Rather this language is

A third guiding principle of the Court's substantive due process jurisprudence is its recognition that interests for which heightened constitutional protection is sought must be identified with specificity and with an eye toward the factual context in which that interest is asserted. *Reno v. Flores*, 507 U.S. 292, 302 (1993) (substantive due process claims must begin with a "careful description of the asserted right"); *Collins v. City of Harker Heights*, 503 U.S. 115, 126 (1992). Whether a state can constitutionally forbid or authorize certain conduct cannot be answered by describing the conduct in its most abstract or generic terms. States, for example, may not forbid individuals of different races to marry, *Loving v. Virginia*, 388 U.S. 1 (1967), but they can prohibit polygamous unions, *Reynolds v. United States*, 98 U.S. 145 (1878), or marriages between members of the same immediate family or persons of the same gender. 52 Am.Jur.2d *Marriage* §§ 62-63 (2d ed. 1970) (marriages between closely related persons are universally proscribed). Likewise, a state may not prevent parents from sending their children to private schools, *Pierce v. Society of Sisters*, *supra*, or from providing them instruction in a foreign language, *Meyer v. Nebraska*, *supra*, but can require that they attend school and receive instruction in English.[7]

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descriptive, not prescriptive. *See, e.g., Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) (discussing the "right to be let alone").

[7] *Meyer*, 262 U.S. at 402 (dicta) ("The power of the state to compel attendance at some school and to make reasonable regulations for all schools, including a requirement that they shall give instructions in English, is not questioned"); *Pierce v. Society of Sisters*, 268 U.S. at 534 (dicta) ("No question is raised concerning the power of the state reasonably to regulate all schools, to inspect, supervise and examine them, their teachers and pupils; to require that all children of proper age attend some school, that teachers shall be of good moral character and patriotic disposition, that certain studies plainly essential to good citizenship must be taught,

Thus, whether interracial, polygamous, or incestuous unions may constitutionally be prohibited cannot be answered merely by framing the conduct at issue as an exercise of the "right to marry," just as the constitutionality of a law touching education cannot be determined merely by invoking a generic parental right to control the upbringing of one's child. Individual justices have disagreed about the precise level of specificity with which a particular interest must be characterized,[8] but the impossibility of reconciling the Court's various due process decisions based on mere recitation of such abstract rights as the "right to marry" or "right to control the upbringing of one's child" demonstrates that considerable specificity in articulating the precise interest at issue is necessary.

2. *Assisted Suicide Fails This Court's Due Process Test.*

Application of these three criteria—consistency with constitutional text, grounding in history, and factual specificity in the description of the underlying interest—to the conduct at issue here at once demonstrates that, contrary to the Ninth Circuit's decision, *Compassion in Dying*, 79 F.3d at 793, 802, "terminally ill, competent adults" have no due process "right to die." First, it is impossible to reconcile recognition of a "right to die" with the actual text of the Constitution. On the contrary, the Due Process Clause protects "life." U.S. Const.,

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and that nothing be taught which is manifestly inimical to the public welfare").

[8] *Compare Michael H. v. Gerald D.*, 491 U.S. 110, 118-30 (1989) (Scalia, J.) (considering a father's interest in asserting parental rights over a child whose mother was at all times married to another man), *with id.*, 491 U.S. at 132 (O'Connor, J., concurring in part) (stating that "[o]n occasion the Court has characterized relevant traditions protecting asserted rights at levels of generality that might not be 'the most specific level' available"), *and with id.*, 491 U.S. at 136 (Brennan, J., dissenting) (stating that fathers have a constitutionally protected interest in their relationship with their children).

amend. 14. Accordingly, there can be no constitutional guarantee to choose to be *dead*. Indeed, life is more fundamental than any other right, for it is the "right to have rights." *Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring). Even outside a constitutional context, American courts generally have rejected *any* claim that there is a legal interest in not being alive.[9]

The Due Process Clause also guarantees "liberty." But choosing to be dead does not enhance one's liberty. Instead it brings all human freedom to an end. It is difficult to see how one can speak coherently of a freedom to give up all one's freedom. Self-destruction is clearly a far more radical renunciation of freedom than, for example, selling oneself to another person, for it is irreversible and eliminates the potential for exercising all other liberties. In short, the Due Process Clause, which is framed as a guarantee against the *deprivation* of life and liberty, would be turned on its head were it construed as requiring the state to permit individuals to assist others in *abandoning* their life and liberty.

Our Constitution has never been understood as requiring states to permit individuals to relinquish their liberty

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[9] *See, e.g., Lininger v. Eisenbaum*, 764 P.2d 1202, 1212 (Colo. 1988) ("life, however impaired and regardless of any attendant expenses, cannot rationally be said to be a detriment . . . when measured against the alternative of . . . not having existed at all"); *Azzolino v. Dingfelder*, 315 N.C. 103, 111, 337 S.E.2d 528, 533 (1985) ("[W]e are unwilling to say that life, even life with severe defects, may ever amount to a legal injury"), *cert. denied*, 479 U.S. 835 (1986); *Elliott v. Brown*, 361 So.2d 546, 548 (Ala. 1978) ("[T]here is no legal right not to be born. . . . Upon what legal foundation is the court to determine that it is better not to have been born than to be born with deformities? . . . We decline to pronounce judgment in the imponderable area of non-existence"); *Becker v. Schwartz*, 46 N.Y.2d 401, 411, 386 N.E.2d 807, 812 (N.Y. 1978) (rejecting a claim of wrongful life "in view of the very nearly uniform high value which the law and mankind has placed on human life").

even when that is what they claim to want. American law, for example, does not recognize under any circumstances a transaction to sell oneself into permanent servitude. *Memphis v. Greene*, 451 U.S. 100, 120 (1981). A host of far less serious interests, and even statutory interests like the right to be paid a minimum wage, may not be waived. *Brooklyn Savings Bank v. O'Neil*, 324 U.S. 697, 706-07 (1945). Similarly, the law will not enforce an unconscionable bargain or a contract that violates public policy, even if the parties freely agreed to it. *E.g., Stamford Bd. of Educ. v. Stamford Educ. Ass'n*, 697 F.2d 70, 73 (2d Cir. 1982). If the law can prevent waiver of these lesser interests, it would be inexplicable if the state were constitutionally required to stand idle while an individual, alone or with assistance, renounced the one interest upon which all these others depend. It is life itself, as well as liberty, that the founding fathers declared to be "inalienable."

Recognition of a "right to die" on the part of terminally ill, competent adults also creates serious questions of consistency with other constitutional provisions. One court, for example, has concluded that the failure to protect a class of citizens from self-inflicted deadly harm violates the Equal Protection Clause, *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (permanent injunction), *appeal pending*, No. 95-35804 (9th Cir.); *but see Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, No. 95-1858 (U.S.). It may violate federal statutes, such as the Americans with Disabilities Act, which protects the disabled. *Lee v. Oregon*, 869 F. Supp. 1491, 1499 (D. Or. 1994) (preliminary injunction).

The equal protection concerns implicated here are obvious. Singling out the terminally ill as a class of persons who "deserve" to have their suicidal impulses implemented—even as the law continues to forbid assistance in suicide for everyone else—presupposes that, in some objective sense, their lives in particular are no longer

worth living. This at bottom would reflect a judgment by the state that some people are better off dead than alive. A civilized society, and certainly a society that guarantees equal justice under the law, makes no such judgment with respect to any person. A judicial declaration that some citizens have a "right to die" would also be in direct conflict with the decision by almost every State legislature in the Union to preserve a uniform prohibition against assisted suicide, raising profound questions of federalism and separation of powers. Some have even suggested that the federal judiciary's sudden discovery of a "right to die" raises questions about the continued capacity of Americans to debate and devise democratic solutions to the important modern questions facing them. *Compassion in Dying v. Washington*, 85 F.3d 1440, 1446-51 (9th Cir. 1996) (Trott, J., dissenting from the denial of rehearing *en banc* by the full court).

This Court, however, need not resolve these complex questions to decide this case because assisted suicide, even were it not in actual *conflict* with the text of the Constitution, clearly does not satisfy the historical criterion that this Court, over the course of nearly a century, has established as the pre-eminent test for identifying substantive interests whose protection is *mandated* under the Due Process Clause. After reviewing societal attitudes about suicide in the last two millennia, what is probably the most exhaustive modern historical-legal analysis of suicide in this country concludes:

> [T]here is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed "fundamental" or "implicit in the concept of ordered liberty." Indeed, the weight of authority in the United States, from colonial days through at least the 1970s has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide. It follows that courts should not hold suicide or its assistance to be a protected right under the United States Constitution.

Thomas Marzen, *et al., Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 4 (Fall 1985). Relying in part on the Marzen study, Justice Scalia has observed that there is no historical support for a right to assisted suicide:

> At common law in England, a suicide . . . was criminally liable. Although the States abolished the penalties imposed by the common law (*i.e.*, forfeiture and ignominious burial), they did so to spare the innocent family and not to legitimize the act. Case law at the time of the adoption of the Fourteenth Amendment generally held that assisting suicide was a criminal offense. The System of Penal Law presented to the House of Representatives by Representative Livingston in 1828 would have criminalized assisted suicide. The Field Penal Code, adopted by the Dakota Territory in 1877, proscribed attempted suicide and assisted suicide. And most States that did not explicitly prohibit assisted suicide in 1868 recognized, when the issue arose in the 50 years following the Fourteenth Amendment's ratification, that assisted and (in some cases) attempted suicide were unlawful. Thus, there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed "fundamental" or "implicit in the concept of ordered liberty."

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 294-95 (1990) (Scalia, J., concurring) (citations and internal punctuation omitted). Except for the Ninth Circuit, lower courts are in agreement with this view. *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir. 1996), *citing* Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 561 (1995); *see also People v. Kevorkian*, 527 N.W.2d 714, 733 (Mich. 1994) (stating that it "would be an impermissibly radical departure from existing tradition and from the principles that underlie that tradition to declare that there is . . . a fundamental right [to assistance in com-

mitting suicide] protected by the Due Process Clause"), *cert. denied*, 115 S.Ct. 1795 (1995); *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995) (panel) (no constitutional right to aid in killing oneself has been recognized in "the two hundred and five years of our existence"), *rev'd*, 79 F.3d 790 (9th Cir. 1996) (*en banc*). The Ninth Circuit's historical account is flawed both in method and in its findings. The fact that mankind's view of suicide is "checkered," *Compassion in Dying*, 79 F.3d at 806, or that suicide met with mixed attitudes in ancient times, *id.* at 806-07, does not show that it is "deeply rooted in *this* Nation's history and traditions." *Moore v. East Cleveland*, 431 U.S. at 504 (emphasis added).[10] The Ninth Circuit's assessment of the Christian tradition on suicide is certainly mistaken.[11]

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[10] Parents in ancient Greece could slaughter or abandon their children if weak or deformed, *see* Will Durant, The Life of Greece 50 (1939), but this is no proof that the practice is deeply rooted in American history and traditions. This Court has never hesitated to reject ancient attitudes, especially when based on ideas that are inconsistent with those ideas upon which our American institutions rest. *E.g., Meyer v. Nebraska*, 262 U.S. 390, 401-02 (1923) (ancient Greek notions concerning child rearing were based on ideas about the relation between the individual and the state which are "wholly different from those upon which our institutions rest," and no legislature could impose similar restrictions on our people "without doing violence to both letter and spirit of the Constitution").

[11] "The Church's tradition has always rejected [suicide] as a gravely evil choice." Pope John Paul II, Encyclical Letter *Evangelium Vitae*, ¶ 66 (March 25, 1995). The single clear instance of "assisted suicide" in the Old Testament, involving the death of Saul, is treated as a capital crime (2 Samuel 1:6-16). The Christian tradition views Judas's suicide not as an act of repentance (*cf.* 79 F.3d at 808 n.25), but as an act of despair. Justin, Cyprian, Tertullian, Clement of Alexandria, Lactantius, Augustine, and other early Christian thinkers all rejected suicide. Darrel W. Amundsen, Medicine, Society, and Faith in the Ancient and Medieval Worlds 89-102 (Johns Hopkins Univ. 1996). Suicide was seen as murder of oneself, and sometimes as worse than murder; according to John Chrysostom, "if it is base to destroy others, much more is it [base] to destroy one's self." *Id.* at 98. Christian leaders praised martyrs

With respect to the Ninth Circuit's treatment of suicide in more modern times, the lessening and eventual removal of criminal penalties for persons who unsuccessfully attempted suicide does not suggest approval of the practice. "Although the States abolished the penalties . . . of forfeiture and ignominious burial, they did so to spare the innocent family and not to legitimize the act." *Cruzan*, 497 U.S. at 294-95 (Scalia, J., concurring) (internal punctuation altered). That stakes are no longer driven through the bodies of persons who commit suicide, *see Compassion in Dying*, 79 F.3d at 809, is no modern-day endorsement of suicide. Our current understanding of assisted suicide is informed by undisputed evidence that virtually all who commit suicide (95% in almost every study) have "a major psychiatric illness at the time of death." New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 123 (May 1994); P. Marzuk, *et al., Increase in Suicide by Asphyxiation in New York City After the Publication of Final Exit*, 329 New Eng. J. Med. 1508, 1510 (Nov. 11, 1993) ("95 percent of all persons who commit suicide have a serious mental illness").[12] It is for such reasons, and not because of societal

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who adhered to their faith even under threat of death, but criticized those who rushed to a martyr's death too readily. The point of martyrdom was to remain faithful, not to intend one's death. The Ninth Circuit was wholly mistaken in suggesting that St. Augustine's chief concern about suicide was the toll it was taking on faithful Christians (79 F.3d at 808), since Augustine strongly condemned suicides by heretics whose teaching and activities he vigorously opposed. Amundsen at 109-111. Equally mistaken is the Ninth Circuit's claim (79 F.3d at 808) that St. Thomas More favored euthanasia because it is mentioned in his fictional work on the imaginary *pagan* society of Utopia. *See* Thomas More, Utopia 102 (Penguin Books 1965). More's Utopia also allowed divorce (*id.* at 104), but the real-life Thomas More was beheaded for refusing to accept King Henry VIII's divorce.

[12] In fact, terminally ill patients expressing suicidal thoughts usually abandon the wish to commit suicide after their depression has been treated or they have received other appropriate medical

approval, that suicide itself is not now punished under the criminal law.

The criminal proscription of assisted suicide, of course, is a longstanding tradition that continues to the present day. The consistency of that proscription has an immediate bearing on the inquiry regarding its constitutional status. Whatever else can be said of substantive due process, this much is true: it surely cannot protect conduct *expressly* prohibited throughout our nation's history. *Michael H. v. Gerald D.*, 491 U.S. 110, 122 n.2 (1989); *see also Bowers v. Hardwick*, 478 U.S. 186, 194 (1986) (longstanding proscriptions against homosexual sodomy render any claim to substantive due process protection "at best, facetious"). Protection of a particular interest "need not take the form of an explicit constitutional provision or statutory guarantee" to warrant protection under the Due Process Clause, "but it must at least exclude . . . a societal tradition of enacting laws *denying* the interest." *Michael H. v. Gerald D.*, 492 U.S. at 122 n.2 (original emphasis).

The Ninth Circuit facilely asserts that sometimes history is not a guarantor of fairness, as illustrated by our nation's tragic history of racial discrimination. But now-obsolete and rejected laws condoning racial discrimination are easily distinguishable. Formerly a disgraceful part of our nation's laws and traditions, racial discrimination was specifically targeted in the thirteenth and fourteenth amendments. Clearly the fact that some laws which furthered racial discrimination were once on the books does not prevent one from finding such laws unconstitutional now. *Loving v. Virginia, supra.* The practices of slavery and racial discrimination are precisely examples of those "traditions from which [our nation] broke," *Planned Parenthood v. Casey*, 505 U.S. at 850, for it was precisely

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treatment. New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context, x, 120-21.

for that purpose that the fourteenth amendment was enacted. In *Loving*, the Court further grounded its decision in history when it observed that the freedom to marry "has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men." *Loving*, 388 U.S. at 12.

Finally, the "right to die" or to "control the time and manner of one's death," *Compassion in Dying*, 79 F.3d at 802, lacks the requisite specificity used in describing substantive due process interests. First, the Ninth Circuit used these very same terms to describe radically different types of conduct, *i.e.*, refusing medical treatment and obtaining a deadly poison, even though these have been treated quite differently under the law.[18] Moreover, a "right to control the time and manner of one's death" expresses *no* limitation in terms of conduct or the actor. Such a claimed right would seem to encompass, for instance, a right to die by gunfire in full view of paying spectators, or by any other means one chose. Nor does the claimed right express any limitation with respect to who may "assist." *See Compassion in Dying v. Washington*, 79 F.3d at 838 n.140 (noting that family members and others may also be involved in facilitating an assisted suicide). For these reasons, one must reject the claimed "right to die" or to "control the time and manner of one's death." Stripped of euphemism, what is at stake here is a claimed "right" to enlist the aid of others in committing suicide. There is no such right.

B. *Planned Parenthood v. Casey* Does Not Alter the Due Process Methodology or Establish A Right To Assisted Suicide.

In *Planned Parenthood v. Casey*, a plurality opinion for this Court characterized abortion as an "intimate and per-

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[18] These amici discuss the difference between assisting suicide and rejecting medical treatment in their brief *amici curiae* in *Vacco v. Quill*, No. 95-1858.

sonal" choice, one "central to personal dignity and autonomy." *Planned Parenthood v. Casey*, 505 U.S. at 851. "At the heart of liberty," the plurality wrote, "is the right to define one's own concept of existence. . . ." *Id.* The court below believed assisted suicide to be constitutionally protected because it too is "intimate," "personal," and part of the "right to define one's own concept of existence."

The claim leads to absurd results. If a decision need only be "personal" and "intimate" to qualify for constitutional protection, then the number of interests entitled to constitutional protection and beyond the scope of state regulation will be large indeed. A decision to use hallucinogenic drugs for recreation, engage in a consensual duel, sell one's body into prostitution, or any number of other equally personal and intimate activities currently subject to state prohibition would be constitutionally protected. Furthermore, if the fact that a choice is "intimate and personal" is enough to guarantee its protection under the fourteenth amendment, then the asserted right to commit suicide could not plausibly be confined to the terminally ill. A decision to commit suicide because of a failing business or family tragedy would seem just as "intimate" and "personal" as a decision to commit suicide based on other reasons or no reason. *Compassion in Dying v. Washington*, 49 F.3d at 591 (if terminally ill persons have a right to commit suicide, "every man and woman in the United States must enjoy" the right—"a *reductio ad absurdum*"), *rev'd*, 79 F.3d 790 (9th Cir. 1996). The same could be said of attempts to defend such a right in terms of the "suffering" of the terminally ill. Other kinds of human suffering are as "personal" and some are more long-lasting. In recognition of this fact, the only nation in the world to experiment for a number of years with legally permitted euthanasia has quickly moved from cases of terminal illness to those involving chronic conditions

and even purely mental suffering.[14] The "personal" nature of suicide proves nothing because it proves too much.

Indeed, there is an especially strong reason to believe in this litigious society that such a claimed right to assisted suicide would not stop with the terminally ill.[15] As Justice Cardozo observed, any principle tends "to expand itself to the limit of its logic." Benjamin N. Cardozo, Nature of the Judicial Process 51 (Yale University Press 1949). Once *any* right to assisted suicide is conceded for any class of persons, it will be impossible to confine the right to that class. Indeed, if such a right were recognized, it could be argued in the criminal law context that killing those who cannot be proven to have objected to the act constitutes no crime at all. This would represent a 180-degree change in the direction of the criminal law to date. *Blackburn v. State*, 23 Ohio St. 146, 163 (1873) ("The lives of all are equally under the protection of the law, and under that protection to their last moment"); *Martin v. Commonwealth*, 184 Va. 1009, 1018, 37 S.E.2d 43, 47 (Va. 1946) (right to life is inalienable; consent of victim is no defense). Since all medical conditions can be placed on a continuum, any distinction based on the health status of the victim would be subject to challenge as arbitrary. Other classes of sick or suffering people would demand a right to assisted suicide on equal

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[14] House Judiciary Subcommittee on the Constitution, 104th Cong., 2d Sess., *Physician-Assisted Suicide and Euthanasia in the Netherlands* 6-12, 15-16 (September 1996) (Report of Chairman Charles T. Canady).

[15] Defining the term "terminally ill" itself has proven to be problematic. "[S]eventeen years of experience with State Living Will statutes that have used 'terminal condition' as a prerequisite to patient directives have demonstrated that 'terminal' lacks any truly objective, operational definition. The terminal requirement is an . . . unworkable requirement." American Bar Association Commission on Legal Problems of the Elderly, Memorandum of January 17, 1992, *reprinted in* 8 Issues in Law & Medicine 117 (Summer 1992).

protection grounds. There is no principled basis for distinguishing among the "depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old. . . ." *Compassion in Dying v. Washington*, 49 F.3d at 591, *rev'd* 79 F.3d 791 (9th Cir. 1996).

Casey is in any event readily distinguishable from cases involving an asserted right to suicide or assisted suicide. The *stare decisis* considerations which led a plurality of this Court in *Casey* to reaffirm the "central holding" of *Roe* are entirely absent—and indeed, tilt in the opposite direction—when one turns to assisted suicide. Assisted suicide not only has no precedent to support it, but is universally proscribed.

Furthermore, this Court has always permitted abortion regulation it deemed necessary to protect a woman's life and health. *E.g., Roe v. Wade*, 410 U.S. at 164. It has even conceded that bans on abortion were more legally defensible in ages when it was "an inherently hazardous procedure" for the woman. *Id.* at 149-50. By contrast, support of a right to suicide is plainly incompatible with protection of health because it destroys the subject's very life. Suicide is always "an inherently hazardous procedure." Finally, except in the abortion context this Court has never ruled that states are constitutionally required to permit the destruction of innocent human life. The Court permitted the destruction of unborn children only because, in its view, they were not persons. *Roe*, 410 U.S. at 158 ("the word 'person,' as used in the Fourteenth Amendment, does not include the unborn"). No party in this case contests the fact that the terminally ill are "persons" and so are entitled to the Constitution's protection.

II. THIS CASE RAISES FUNDAMENTAL QUESTIONS ABOUT THE ROLE AND RULE OF LAW IN THIS SOCIETY.

Ours is a Nation founded not simply upon boundless or unprincipled liberty, but on *ordered* liberty. *Palko v. Connecticut*, 302 U.S. at 325. It follows that one does not have an absolute right to do with one's own body, or anyone else's, as he or she pleases. *Roe v. Wade*, 410 U.S. at 154. The "statute books are replete with constitutionally unchallenged laws against prostitution, suicide, voluntary self-mutilation, brutalizing 'bare fist' prize fights, and duels, although these crimes may only directly involve 'consenting adults.'" *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1973). The choice of a spouse is perhaps the most intimate of choices, but that choice too is qualified by concerns for the common good that are expressed in limitations based on affinity, consanguinity, and gender. In each of these instances, the claims of an individual are balanced against, and sometimes subordinated to, the common good.

For many reasons, the common good counsels strongly against physician-assisted suicide. Public policy is not made at the extremes or for the extremes. Medical evidence shows clearly that most of those who express desires to end their lives have a treatable depression or other psychopathology.[16] Some, though not the majority, of persons who request suicide are in pain.[17] Once these conditions are treated, however, the demand to end life ceases.[18] If we embrace a "right to die" as designed by the

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[16] *See* discussion, *supra*, at 19.

[17] *See* P.J. van der Maas, *et al.*, Euthanasia and Other Medical Decisions Concerning the End of Life 44 (Elsevier Science Publishing 1992).

[18] "Adequate pain relief, control of symptoms, and treatment of psychological distress clearly alter patients' requests to terminate life." Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. of Pain and Symptom Management 289, 296 (1991).

court below, those who would die prematurely by exercising that "right" are those most in need of care and comfort, those most vulnerable to disparities in economic and health care resources.[10]

A New York State Task Force that studied this issue predicted that the poor, the elderly, minorities, and those without access to medical care are more likely to be encouraged to request "aid" in dying (or have it requested "for" them by surrogates) than any other class if assisted suicide is legalized. New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context, xii (May 1994). Others have noted the disproportionate impact that legalization of assisted suicide would have on women. American Association of Suicidology, *Report of the Committee on Physician-Assisted Suicide and Euthanasia*, 26 Suicide & Life-Threatening Behavior 9 (1996 Supp.). It was for this reason, among others, that the diverse members of the New York State Task Force on Life and the Law unanimously rejected the view that the State's prohibition against assisted suicide should be altered in any way:

> No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.

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[10] Individuals treated at centers serving predominantly minority patients have been found to be three times more likely than others to receive inadequate pain treatment, with women and the elderly also more likely to receive poor treatment. C.S. Cleeland, *et al.*, *Pain and its Treatment in Outpatients with Metastatic Cancer*, 330 New Eng. J. Medicine 592-6 (1994). "Pain is . . . more likely to be undertreated if the patient is minority, female, elderly, or a child." State of California, Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing 3 (Summit Report 1994).

New York State Task Force on Life and the Law, *supra* at xiii. We need to consider—and this Court needs to confront—the larger consequences for education, economic reform, the eradication of poverty, discrimination, and other ills of society if we foster the attitude that, in the face of seemingly intractable difficulties, it is an individual's right not only to surrender but to enlist others to provide the means to end his or her life. The prohibition against intentional killing "is the cornerstone of law and of social relationships." House of Lords, 1 Report of the Select Committee on Medical Ethics 48 (Jan. 31, 1994). It is surely constitutional.

This case asks plainly how constitutional law and constitutional principle can and should develop over the foreseeable future. It asks whether the rule of law, which traditionally has prevented people from enlisting others to carry out self-destructive impulses, may crumble in the face of a newly-minted claim of unbridled autonomy. It asks whether traditional and valued distinctions in the law and in medical practice must give way to these new claims of autonomy—claims which are self-contradictory, for they destroy the very person whose freedom they claim to maximize. At bottom, this case asks whether the kind of society we are to become will reflect our deepest values or none at all. No person or class of persons should be labeled by our legal system as having a life not worth living. Our society is made richer through the lives and well-being of all.

CONCLUSION

For the foregoing reasons, the judgment of the Ninth Circuit should be reversed.

Respectfully submitted,

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Nos. 95-1858, 96-110

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

and

STATE OF WASHINGTON, CHRISTINE O. GREGIORE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF PROLIFE NURSES, NATIONAL ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION IN LONG TERM CARE, PHILIPPINE NURSES ASSOCIATION OF AMERICA, SCHOLL INSTITUTE OF BIOETHICS, CALIFORNIA NURSES FOR ETHICAL STANDARDS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*:

The decisions of the Courts of Appeal damage the liberty and property rights of nurses.

Letters of the parties consenting to file this brief *amici curiae* have been filed with the Court. Descriptions of each group filing this *amici* brief are set forth in the Appendix.

By striking state laws criminalizing assisted suicide, the decisions of the Courts of Appeal, if affirmed, would make assisted suicide legal. The *amici curiae* will be uniquely and directly affected by the Court's decision in this case. To demonstrate their unique interest, *amici* will present evidence that nurses would be 1) involved, and 2) detrimentally affected, if assisted suicide were made legal.

The decisions of the Courts of Appeal on review grant an entitlement not only to "physician-assisted suicide" but also (a fact unknown to many) to "nurse-assisted suicide." The practitioner most likely to be with the patient as he dies, is his nurse. A large difference exists between the professions of nursing and other professionals in illness care, regarding the care of terminal patients. The patients who are the subject of assisted suicide almost always require nursing care, not always medical care. At the very time when medicine may have little to offer the patient, the nurse can give comfort, concern, and care. The interest of nurses in what happens to their dying patients is unique, even among other professionals.

The nurses' interest differs from other professionals in another way: nurses are almost always employees. They will not have the luxury that other professions might have, abstractly and coolly to deliberate on whether to assist a patient in suicide. Nurses rarely can choose their patients; they are assigned to them. Because of their societal and employment status, nurses would be vulnerable to pressures to assist in suicide against their professional or ethical judgment. They are often in the unenviable position of being responsible for executing decisions in which they have no voice. The nursing coat of arms in some instances might well read: "Responsibility without Authority."

The effect of inculpating nurses in the self-killing of their patients will not be addressed by any other *amici* or Party. The effect is this: If assisted suicide is made legal, nurses will be asked to assist suicide. All nurses care for patients who die, and some of their patients might die by prescription. That nursing care would be nurse assistance in suicide, because the definition of "assist" cannot be narrowly limited only to providing medication. Those nurses and thus the whole profession would be inculpated in nurse-assisted suicide. Further, Nurse Practitioners (NPs) in several states now legally prescribe the medications that would be used to cause death in patients.

The Nurses' concern for their *patients* who would be harmed, will be addressed by other *amici*. Nurses add that the harm done to the profession of nurses, the largest group of practitioners who care for patients, would affect not only current patients but all who would need nursing care in the future.

All nurses would be involved intimately in the death of their patients who might self-kill. The decision of one of the Courts of Appeal contemplates this, together with an assumption that at some future time euthanasia may be delegated:

> "We recognize that in some instances, the patient may be unable to self-administer the drugs [for suicide] and that administration by the physician, **or a person acting under his direction or control** may be the only way the patient may be able to receive them." [Emphasis and material in brackets added]. *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 at 831 (9th Cir.1996).

The inevitable inculpation of nurses in legal assisted suicide would erode the personal and professional ethics of nurses, expose them to criminal and civil sanctions, and destroy the confidence of the public in the profession. Thus the nurses' rights to liberty and property in the practice of their profession would be violated.

SUMMARY OF ARGUMENT

The decisions of the Courts of Appeal grant the entitlement to suicide with assistance and approval and thereby deny liberty and property rights of nurses in their profession, damaged irrevocably by nurse assistance in the deliberate deaths of patients. Nurses would be 1) inculpated, and 2) harmed, by legal assisted suicide:

1. Under legal assisted suicide, nurse practitioners and all other nurses would be inculpated in nurse-assisted suicide. One association of nurses already has advised its members that nurses would be involved in assisting suicide if it were legal.
2. Legal assisted suicide would harm irrevocably the ethical and legal basis of the nursing profession; current ethical standards of nurses would be eroded; and the public's perception of the profession would deteriorate, all causing damage to the liberty and property rights of nurses in practicing their profession.

ARGUMENT

To commit suicide with assistance and approval is not a right but an entitlement. Making assisted suicide legal does not merely allow the ability to do an act by one person, but confers the power to involve another person in the act.

Nurses leave to other *amici* the elaboration of the certain fact that the vast majority of people who seek suicide are psychologically impaired. Even terminal patients in pain do not seek death (and *amici* assert this pain can be relieved, under current standards of care). E.J. Emanuel, *et al, Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, 347 Lancet 1805 (1996).

Terminally ill patients who seek to die are almost invariably depressed and ambivalent about dying, and those patients can be helped with medication. If encouraged, such ambivalent patients will choose to live. For the rare patient who is terminal, competent, non-depressed and seeking suicide with help (and even that patient is likely ambivalent about dying):

Before these Courts of Appeal decisions, prescriptions have been written with knowledge that their purpose was suicide. Though that information has been acknowledged, no prescribers have ever been convicted of assisting suicide. T.H. Stone & W.J. Winslade, *Physician-assisted suicide and euthanasia in the United States*, 16 J. Leg. Med. at 492 (1995).

The aim of making assisted suicide legal, then can be seen. It is not merely to allow a prescription for the few competent, terminal, non-depressed patients who would commit suicide with such drugs. Instead, it provides a prescription *with approval of its purpose*. This prescription would be visible evidence of approval of the act from the doctor or nurse practitioner. Legal assisted suicide confers the entitlement to suicide with approval, by inculpating the professions. The intent is to give to the act the imprimatur and approval of the law, and of the professional.

The tacit tolerance of assisted suicide already creates the perception that some special cases exist that warrant assisted suicide. This tolerance would become explicit if legal. The nurse would be forced to act either in compliance with her conscience (to safeguard her patient, profession, and opinion of herself), or to act in compliance with what would then be the law. She would have to be silent or even assist suicide.

1. Legal assisted suicide would inculpate all nurses in assisted suicide, denying nurses the liberty and property interests in their profession.

The relationship of nurses to their patients has been called a social contract with the public. That is, the public/patient knows in general what a nurse is, and what she is expected to do. People who are currently in the profession entered that work with the knowledge of, and expectation of, what their work would be. They have a property interest in their occupation; and they have a liberty interest in being able to practice the profession as it exists without arbitrary government interference. Both interests have been found to rise to the level of fundamental rights, deserving Constitutional protection.

> " . . . [T]he right to work for a living in the common occupations of the community is of the very essence of the personal freedom and opportunity that it was the purpose of the Amendment to secure."

Truax v. *Raich*, 239 U.S. at 41 (1915); and

> "[T]he right to hold specific private employment **and to follow a chosen profession** free from unreasonable governmental interference comes within the 'liberty' and 'property' concepts of the Fifth Amendment."

Greene v. *McElroy*, 360 U.S. at 492 (1959) [Emphasis and material in brackets added].

The liberty and property interests asserted here are not merely in a specific job, though specific employment also may be endangered for the nurse who will not participate. The nurse who will not participate in assisting suicide cannot merely go to another nursing job that is unaffected by legal assisted suicide. Any and all nurses would find their profession damaged by the inculpation of nurses in assisted suicide. All jobs, all nurses, would be tainted.

The practice of nursing does evolve and change; but the underlying values expressed in the ethics of nursing, and enforced in the minimum of the law, have not changed in thousands of years. The *amici* assert that it has not ever been the legitimate work of their profession to assist patients to kill themselves. Legal assisted suicide would make those acts part of the work of nurses.

Courts have always considered the effect of their decisions on all the people involved in a case. Under these decisions, the nurses are immediately and intimately and detrimentally involved. In particular, the impact of their decisions on the integrity of the professions has been of major concern to courts. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980).

Other courts have expressed concern for nurses asked to assist in causing death in their patients (in the case quoted below, by denying nursing care).

> I find it difficult to understand how we can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care. [Such an order] may impinge on the privacy rights of those nursing professionals.

In re Jobes, 529 A.2d at 464 (N.J. 1987) (O'Hern, J., dissenting). [Material in brackets added].

Another court worried about the ethics of nurses asked to assist in deliberately dehydrating to death a comatose patient:

> . . . for almost all concerned the adoption of the proposed course will be a merciful relief, [but] this will not be so for the nursing staff, who will be called on to act in a way which must be contrary to all their instincts, training and conditions. They will encounter the ethical problems, not in a court or in a lecture room, but face to face.

Lord Mistill, House of Lords. *Airedale NHS Trust (Respondents)* v. *Bland* (Acting by his guardian *ad litem*) (Appellant) London: House of Lords, 1993 [Material in brackets added].

a. Legal assisted suicide would inculpate nurse practitioners as prescribers of drugs used in suicide.

If assisted suicide were legal, nurse practitioners in many states would be affected in exactly the same way as physicians. They would be seen as practitioners who could prescribe death instead of promoting life. In some states nurse practitioners potentially can prescribe all the drugs that patients seeking to suicide most likely would be prescribed to kill them. Drugs that might be prescribed are used at present for pain, sleep, anxiety, or depression, all of which categories some nurse practitioners legally can prescribe now. See, for example, Or. Rev. Stat. 678.385.

Patients who could legally obtain drugs for the purpose of suicide from physicians could get a prescription for the same or similar drug from a nurse practitioner. This is so, even if the NP technically could not prescribe for the *purpose* of suicide. If prescriptions from the physician for the purpose

of assisted suicide were legal, patients would be encouraged (and perhaps even more likely) to ask for the same drugs from their nurse practitioner. Patients who formerly might not have sought a prescription for suicide might be encouraged to do so if it were legal. The legality of the prescription would remove the stigma from suicide or at least spread it onto the prescriber.

Nurse practitioners in the future likely would be included as "prescribers" if assisting suicide were legal. The equal protection clause of the Fourteenth Amendment to the Constitution would prohibit the exclusion of Nurse Practitioners from prescribing drugs for self-killing. The limitation of such prescriptions to physicians would discriminate without rational basis, since nurse practitioners too could prescribe the drugs most likely to be used to kill the patient.

To assert that the prescription of killing drugs could be limited to physicians because they are better qualified to judge the mental status of the patient, has no factual basis. Comparison of the curricula of their respective educational programs would demonstrate that nurse practitioners (especially those working in mental health) are even more likely than doctors to have been educated in psychosocial components of care. Thus nurse practitioners are at least as able as physicians to assess patients for their competency in making a request to die. Nurse practitioners would be inculpated in legal nurse-assisted suicide as prescribers. Their exclusion will not meet the rational basis standard of Amendment Fourteen of the Constitution.

Nurse practitioners unwilling to assist the patient in suicide likely would be required to transfer medical records to the next practitioner chosen to assist suicide, just as physicians would be. This participation would be required, regardless of the religious or moral or professional objections of the nurse to inculpation in the self-killing. The nurse's objection that suicide was inappropriate for this patient, based on her assessment of the patient, would be no bar to enforcing such

transfer of records. An example of such requirement to transfer patient records in a law with "safeguards" as recommended by the decisions of the Courts of Appeal, is Oregon Ballot Measure 16, Section 4.01(4).

b. Nurses other than nurse practitioners would be affected by legal assisted suicide.

(1) The practice of every nurse would be changed by legal assisted suicide (which seeks to solve a nonexistent problem).

Legal assisted suicide would affect all nursing practice; most nurses care for terminal patients on a daily basis. Some of those patients (those who are depressed and ambivalent) might seek suicide with assistance. Participating in assisted suicide would become part of the practice of nursing. The consequences of legal assisted suicide noted below support that conclusion, and it is admitted by the position of the Oregon Nurses Association (ONA) discussed more fully below. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

If assisted suicide were legal, according to the ONA paper discussed below, even the nurse who is morally opposed to assisted suicide would be required to inform the patient of his right to referral to a physician (or nurse practitioner) who would prescribe a lethal dose. For some nurses, supplying this information would be assisting the patient's suicide. They would assist, as surely as did German nurses under National Socialism assist euthanasia. Those German nurses identified some children as retarded, knowing the result of the diagnosis would be death.

From the research done on attitudes and behavior of patients who are terminally ill, it is evident that the Courts of Appeal have written law to solve a problem that does not exist. Data cited above (Emanuel) show that patients who seek suicide are depressed and at least ambivalent about their wish to die. Practitioners are notoriously bad at diagnosing

and treating depression[1] (a reason to educate practitioners, not a reason to assist depressed patients to suicide). The data also show that competent terminal patients, even those (unnecessarily) in pain, are very unlikely to seek suicide.

According to research studies, a large majority of patients want heroic efforts made if they die. They may overestimate the success rate of heroic efforts, but patients who are very seriously ill, even those that might be classed as "terminal," want to live. R.S. Phillips *et al, Choices of seriously ill patients about cardiopulmonary resuscitation: correlates and outcomes*, 100 Am. J. Med. 128 (1996).

At present, the nurse's duty toward a depressed patient dying in pain is to alleviate the pain and treat the depression, both remediable conditions. If assisted suicide were made legal, the nurse's practice would be changed, perhaps to assist the patient to suicide in order to relieve depression and pain. Effective (non-lethal) treatment is available right now for depression and pain. *Amici* know it is not necessary to end the patient, to end his pain.

The Courts of Appeal have confused withdrawing treatment that patients do not want, with suicide, assisted suicide, and euthanasia. Researchers too have confused refusing treatment with suicide, resulting in studies that seem to indicate that intensive care nurses already assist suicide or euthanize patients. D.A. Asch, *The role of critical care nurses in euthanasia and assisted suicide*, 334 N. Eng. J. Med. 1374 (1996). In reality, only treatment that the patient rejects is removed. Often the treatment rejected would not have prolonged the patient's life in any event. The public (including jurists and researchers) overestimate also the success rate of medicine and nursing in prolonging life with heroic efforts.

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[1] Purported safeguards in legislation such as those in Oregon's Measure 16, ask the practitioner to refer the patient who may be depressed for counseling. But many practitioners cannot recognize the diagnosis in the first place, so they cannot refer. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) p. 127.

Though it may be blurry to the Courts of Appeal, the line is very clear and bright between withdrawing treatment which would not prolong life, and actively causing death. Nurses are adamant that care that is not useful, and is not wanted, be ended. The nurse is very often the patient's greatest advocate in such situations. She will take whatever measures are needed to see that the patient's wishes are honored. These measures may include conversations (even confrontations) with doctors, ethics committees and employers. But for the nurse, it is a thousand leagues distance from honoring her patient's wish to stop treatment – to being her patient's agent of death.

Under legal assisted suicide a nurse would encounter a family pressuring the terminal patient to die (subtly or not, and done for the patient's benefit or not). Currently, this behavior might rise to the level of neglect or abuse of an elderly or dependent patient, and the nurse's obligation is to report it. Under legal assisted suicide, the nurse's practice would be changed (perhaps to refer the patient and family to a practitioner who would prescribe a lethal dose).

Under legal assisted suicide, federal law might require nurses to inform the patient who is even possibly "terminal," of his right under state law to assisted suicide. The Patient Self-Determination Act 42 U.S.C. Sec.1395cc(a)(1) *et seq.* requires recipients of Medicare funds (hospitals, skilled nursing facilities, home health agencies, and hospice programs) to provide information to each patient concerning

> "an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."

Even government employers may require practitioners to give information preferred by the employer's policy. *Rust* v. *Sullivan*, 500 U.S. 173 (1991). Private employers surely would be able to dictate information to be given. For employers of nurses such as managed care companies or their contractors (virtually all employers of nurses are included in the latter category), the patient's suicide or euthanasia might

be a very cost effective procedure. If the procedures were legal, nurses would be under pressure to assist suicide and euthanize. Nurses might be expected to suggest such "alternatives" to expensive care.

Nurses could be directed by their employers to tell patients that help in killing themselves is available, or be at risk of losing their jobs. Some nurses from strong religious and ethnic tradition, and other nurses who also place primary value on the life of the patient, would be especially at risk. If legal, such nurses who work on oncology and AIDS units, in long term care, hospice, and home health would find their job opportunities limited if they declined to participate in assisted suicide.

Nurses could be forced to choose between job and conscience in a time of shrinking job opportunities in nursing. Most nurses work as "at will" employees, vulnerable to covert and overt pressures to conform to employer goals. Nurses are career professionals, whose jobs usually provide the main source of income in their families. Many could not afford the luxury of maintaining their ethical standards at the cost of losing their livelihood.

(2) Hospice and home health nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some hospice or home health nurse would visit her patient to find he had obtained a massive overdose of drugs. (If legal, it would be considered not an overdose but a "correct" dose to kill himself.) Before legal assisted suicide, the nurse would have assumed her duty was to help the patient live. After legal assisted suicide, the nurse's duty could conceivably be to counsel how best to take the drugs to assure death.

Under legal assisted suicide, some nurse who made a visit to check on her patient would find the patient had already ingested the prescribed overdose. (If legal, the dose would be called the "correct" dose – to kill the patient.) Currently, the nurse's duty is to call 911 and resuscitate.

Under legal assisted suicide, the nurse's duty might be to remain passively with the patient/family until the death. The ONA paper [cited below] suggests that if no other nurse were available, legal assisted suicide would create a duty to stay passively with the patient until death, regardless of the nurse's strong intent *not* to assist suicide.

The nurse whose patient would die by legal prescription would be inculpated in the death, because such a death is not so swift or sure or painless as might be assumed.[2] The patient may not die immediately or even within several hours or days. In addition to taking the prescription, proponents of suicide advise placing a plastic bag over the patient's head to assure asphyxiation if the patient awakens. This course of events is said to be not uncommon.

The ONA paper below suggests that even the nurse who did not wish to assist the patient in suicide, still would have to assume the patient's "end of life care" if assisted suicide were legal. If she were unable to transfer the suiciding patient to another nurse, she would have no choice but to participate.

Under legal assisted suicide, the nurse's duty might be changed horribly, perhaps extending to placing the plastic bag over the patient's head if the patient were unable to do so.

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[2] Prescribers for legal assisted suicide would not be competent to prescribe for a totally new purpose – to kill. To illustrate the problem: Excellent pain control measures are available, but many physicians and nurse practitioners are still unable to prescribe appropriate pain control for terminal patients. (This is not an excuse to kill the patient to relieve the pain, but a reason for more education of prescribers about the near 100% effective relief available.) Considering that current failing, it would be long before prescribers were good at killing. There is no scientific basis for this practice and doctors and nurse practitioners have had no experience in doing it. A new era of research would result if assisted suicide were legal. Such investigation of how to kill people yielded the Guillotine in the 18th Century, and the gas chamber in the 20th. It might well be asked what rough science slouches toward the 21st Century to be unearthed.

Eyewitnesses assert that it is sometimes necessary to hold the suiciding person's hands as he smothers, to keep him from forcefully removing the bag. The nurse's duty could extend to doing that.

If assisted suicide were legal, a hospice or home health nurse would find a suiciding patient alone and with no plastic bag. Currently the nurse's duty is to call 911 and resuscitate. Under legal assisted suicide the nurse's duty might be changed, to placing a plastic bag herself as noted above. Or her duty might be seen as passive, to leave the patient in a comatose state, visiting later to see if the patient died in the interim. It is highly impractical to say that the nurse would be obligated to stay with such a patient. Patients in a coma may take 11-14 days to die of dehydration (known from the experience of deliberately dehydrating to death, non-dying patients). Ruth Phillips, *The legacy of Nancy Cruzan*, 6(2) Living World 16 (1992).

A failed attempt could result in a very damaged patient, which would encourage or even mandate the nurse to ascertain that her patient does not fail. Nursing practice eventually might extend to directly killing the patient who failed in the suicide attempt. Legal assisted suicide does not prohibit active euthanasia; initially, it merely does not "authorize" it. For example see Oregon Ballot Measure 16, Section 3.14.

(3) Hospital and long term care nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some patients prescribed a lethal dose would choose to take the drug in the hospital or long term care facility. One proposed "safeguard" legislation recognizes that possibility on its face.

> "If the patient [who wishes to suicide] is an inpatient at a health care facility, one of the witnesses [to the request for suicide] shall be an individual designated by the facility."

Oregon Ballot Measure 16, Section 6, "FORM OF THE REQUEST." [Material in brackets added.] The nurse designated by the facility would be faced with assisting suicide at least to the extent of witnessing the patient's request, regardless of her moral, ethical and professional objections.

If the nurse on duty in a hospital or other inpatient facility knows of the patient's plan to suicide beforehand, her duty might change from trying to save the patient's life – to assisting with his death. Currently the nurse continues nursing care for the patient who is dying; turning the patient, suctioning secretions, administering medications, etc., to help the patient *live* comfortably. Under legal assisted suicide, the nurse's practice would change. The duty logically might be to do whatever would cause the patient to die sooner.

Under legal assisted suicide, the "worse" the nurse by present standards (that is, the faster and better at killing), the better for the patient. The "better" the nurse by present standards (that is, the more life-saving, caring), the worse for her patient under legal assisted suicide. The *amici* assert: This situation stands nursing practice on its head.

These vignettes look macabre, but they are not worst-case scenarios; they are the likely situations that nurses would encounter if the Courts of Appeal are affirmed. Immediately, intimately and inextricably, nurses would be inculpated in assisted suicide.

Nursing "care" would be redefined to include the killing of the patient, and assistance as the patient self-kills. Nursing theory would be developed to teach students how to "care" (or, in every accurate usage of the word, how *not* to "care") for patients committing suicide. Continuing education would be needed for current nurses, on how to assist patients being killed by self-administration of drugs. If assisted killing were extended to people unable to self-administer the drugs (as would be likely), nurses would be taught to kill patients directly.

Nursing education and curricula would be changed to incorporate the "new" ethic and law and nursing practice: Some patients would be given good care. Some patients' "good care" would include giving them prescriptions to kill

themselves. And some patients' "care" would include killing them.

c. Anticipation of legal assisted suicide in one state has caused its nurses to accept involvement.

The threat of legal assisted suicide in one state already has prompted a paper in which the nurses association accepts that nurses will be involved in their patients' suicide. In anticipation that legal assisted suicide would be implemented, and to prepare their members for that reality, the Oregon Nurses Association (ONA) adopted a position statement to guide nurses in the care of terminal patients under legal assisted suicide. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

The ONA document asserts that the nurse's role under legal assisted suicide would be "to share information about health choices **that are legal**." [Emphasis added] Oregon Nurses Association, p. 3. This statement is evidence that nurses will be involved if assisted suicide is legal. Nurses would be expected to teach patients about the option of killing themselves. Mere legality (not any higher ethical standard) would be the defining parameter of the nurse's behavior.

Theoretically, under the Oregon "safeguard" legislation which proposed to make assisted suicide legal, the nurse could refuse to care for a patient who chooses to kill himself. But the ONA paper admits that if she couldn't transfer the patient, "the nurse has the responsibility to provide for ongoing end of life care." Oregon Nurses Association, p. 3. Transfer might be impossible if the nurse discovered the suicide attempt after the patient had taken the poison. Requesting and securing a replacement nurse from her agency (if even granted) could take longer than the patient had to live. Nurses could not opt out of legal assisted suicide, no matter what the language of any "safeguard" legislation adopted by a state legislature.

Nurses are competent to make professional judgments about the mental and physical status of their patients that would affect the appropriateness of a request for suicide.

Further, they are competent to make moral judgments for themselves, about the appropriateness of suicide for any person at any time. Regardless, under legal assisted suicide, the ONA paper asserts that the nurse would be involved and would be muzzled:

> "You may not subject your patients or their families to unwarranted, **judgmental** comments or actions because of the patient's choice [to kill himself]."

Oregon Nurses Association, p. 4. [Emphasis and material in brackets added].

The nurse would be involved, her professional judgment would be thwarted and her freedom of speech compromised under legal assisted suicide.

The ONA position paper is evidence that legal assisted suicide would inculpate nurses fully in assisted suicide, and to the detriment of the practice of the profession.

2. Legal assisted suicide would harm the ethics and law of nursing; the threat already has done harm.

a. Legal assisted suicide would erode the ethics and law of nursing.

The inculpation of nurses in assisting patients to kill themselves causes the degeneration of the ethics and law of nursing, which are based on six values (elaborated below): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. The position of the American Nurses Association (ANA) states the ethical foundation of nursing practice:

> "The goals of nursing are the promotion, maintenance, and restoration of health, the prevention of illness, and the alleviation of suffering. The social contract between nursing and society to meet these goals is based upon a code of ethics that is grounded in the basic ethical principles of respect for persons, the noninfliction of harm, and fidelity to recipients of nursing care. These principles command that nurses protect or preserve life, avoid doing harm, and create a relationship of trust and loyalty with recipients of nursing actions."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The ethical standards of conduct (a higher ideal) are used by lawmakers in making lower, legal minimum mandates. Nursing law is the minimum enforcement of nursing ethic. It is the arbitrarily drawn line that separates desired behavior (ethics) from mandated behavior (law). The law exists to guide people who have no higher ethic. People who will not do right voluntarily, can be made to do at least a minimum of "not wrong" with law.

Those people, and others who have no moral compass, will take the law as the highest, not the lowest, standard of behavior. For them, the law becomes the ethic. "It's legal, therefore it must be ethical" is the reasoning. If the nurse who assists suicide were acting legally, some then would assume that she was acting ethically, too.

As noted below regarding nurse participation in executions, the nursing profession nationally has not succumbed to that lowest level of behavior. The national nursing associations, such as the American Nurses Association (ANA) and the National Association of Prolife Nurses, set and promote professional standards of ethics. Those standards cannot be varied according to popularity poll, nor may they descend to whatever acts the popular will has made temporarily legal. As an analogy to assisted suicide: Nursing leaders have suggested that nurses who participate in executions – even if the act is legal – are so far below the ethical standard required of nurses, that their licenses should be revoked.

Assisting a patient to kill herself, merely because it is legal, should not change the standards of nursing practice and ethics; but it would. The legal standard of nursing would be so low that merely to meet it would violate nursing ethics. The standard of nursing ethics and nursing practice would inevitably be ratcheted down to a lower level commensurate with the law.

Some nurses would do whatever is legal. That is why it is not sufficient to say that nurses can protect the ethics of the nursing profession simply by voluntarily refusing to participate in legal assisted suicide. Unlike the isolated participation

in legal executions by a few nurses, *all* nurses are intimately involved in the lives and deaths of dying patients. Under legal assisted suicide, nurses would be inextricably inculpated in their patients' suicides. The erosion of the law would corrupt the ethic correspondingly. Law would lead instead of follow the ethic, and would irreparably harm the profession of nursing.

The ethics and the resulting law of nurses are based on the following six values held by nurses (and all the illness care professions): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. J.K. Hall, *Nursing Ethics and Law* (1996). Discussion of each value follows with its resulting ethic and law and the changes that legal assisted suicide would cause. As the law deteriorates, so do the ethics.

DOING NO HARM

Legal assisted suicide would damage the nursing ethic and law based on the value, *Doing No Harm* (Non-maleficence). That value is enforced by criminal law, civil intentional tort law and licensure law. Currently, nurses can be prosecuted under their licensure law which in most states allows license revocation for conduct which can be characterized as gross incompetence or gross negligence. See, for example, Or. Rev. Stat. 678.111(b). Presently, assisting deliberately caused death in a patient could be characterized at least as gross incompetence or as gross negligence, if not intentional harm. If assisting suicide were legal, the nursing licensure law would have been dramatically changed.

Assisting deliberately caused death now would surely be "conduct derogatory to the standards of nursing," also grounds for licensure discipline in most states. See for example, Or. Rev. Stat. 678.111(f). Again, legalizing assisted suicide would change the licensure law. As noted above, the standards of nursing have been national parameters, not community or state standards subject to the vagaries of what lawmakers set. But the law will lead those who have no ethical guide, and if assisted suicide is legal, nurses who

assist will seem to meet the minimum standard of nursing practice.

Presently, the nurse whose terminal patient is being pressured to commit suicide may be obligated to report that as neglect or abuse of an elderly or dependent patient. See for example Or. Rev. Stat. 410.610 *et seq*. (elderly) and Or. Rev. Stat. 441.630 *et seq*. (nursing home). If assisted suicide were legal, such encouragement might be considered the right thing for family or nurse to do.

Under legal assisted suicide the enforcement of these laws preventing harm to the patient would change. "Safeguard" legislation (such as that passed in Oregon) would have to provide that nurses would not be subject to criminal or civil liability or professional disciplinary action for assisting suicide. Such law would erode the authority of the board that regulates nursing, and any other agencies that enforce the law that prohibits and punishes harm to patients. Allowing nurses to assist in suicide would erode the minimum ethic enforced by the law, and correspondingly lower the standards expected of nurses generally.

DOING GOOD

The nursing ethic based on the value *Doing Good* (Beneficence) is enforced in malpractice law. Currently, when nurses fail to do good (as a reasonable prudent nurse would do), even unintentionally, they are subject to liability. Currently, nurses are not relieved of their own liability for their actions by physician orders and actions or patient wishes; nurses are morally and legally liable for their own malpractice. See generally, *Nurse Liability for Own Malpractice*, 51 ALR 2d 970.

Legal assisted suicide would change the nursing malpractice law. The standard of care of the "reasonable prudent nurse" would be changed from obligation to *save* the patient's life, to obligation to help *end* it in some situations. As noted above, under legal assisted suicide, the nurse would be obligated to inform the patient about the availability of assisted

suicide. Regardless of her personal moral convictions or professional assessment that the patient can be helped short of suicide, the patient or survivors might bring an action for subsequent pain and suffering based on a negligence theory if she did not so inform.

On the other hand, nurses who did refer or assist the patient who sought assisted suicide, might also be liable. The theory of liability could be failure to assess adequately for depression or decisional capacity, or failure to challenge the prescriber's assessment and prescription if they were faulty.

The family member or the estate who learns about the nurse's involvement in the attempt might have a cause of action for malpractice or wrongful death. The family might notify the licensure board of the nurse's action, alleging failure of nursing care. (Though as noted above, the licensure board might be powerless to enforce standards after legal assisted suicide.)

BEING FREE

Legal assisted suicide would damage the nursing ethic based on the value *Being Free* (Autonomy), enforced by consent law. The nurses leave to other *amici* to elaborate on the obvious fact: The patient's autonomy must *not* be honored and he must be protected from himself, if he is not competent to make decisions. That is the situation if the patient is depressed or suffering from mental illness, which almost all suicidal patients are.

The right of the patient to refuse treatment is stronger than the grant of an entitlement (as in legal assisted suicide), but even that power of refusal is not absolute. The right is conditioned on the impact on other people; for example, the power to refuse a transfusion may be conditioned on the patient's responsibility for another person.

Nurses have some rights to their own autonomy. The patient's demand for treatment which transgresses the professional's ethics cannot be honored. For example, the patient's demand to remove a healthy body part (because the person wanted to qualify as disabled) must be declined by the ethical

physician. Even an *un*ethical doctor would face legal sanctions for performing such a procedure. Government cannot arbitrarily inculpate the professions in such entitlement, to the detriment of their fundamental liberty and property rights to practice their profession with autonomy.

A rough analogy to the damage to nurses' autonomy under legal assisted suicide: Imagine a law granting the entitlement to assisted suicide with the help of a police officer to accomplish the killing. The damage is obvious to the ethic of police officers, whose professional responsibility is to protect innocent life. As noted above, the reason to have a professional assist is to put her imprimatur on the act.

Another analogy of damage, to another profession that might serve as provider of assisted suicide (and whose ethics much of the public already consider to be below reproach) is the legal profession. A recent article describes the perception that lawyers will do whatever their clients order, without reservations based on personal integrity or professional ethics. The authors suggest, perhaps not tongue-in-cheek, that the legal profession might be the ideal suicide assistants. R.M. Sade & M.F. Marshall, *Legistrothanatry: A new specialty for assisting in death,* 39(4) Perspectives in Biology and Medicine 547 (1996).

The American Nurses Association addresses the fine line separating the patient's autonomy from the moral mandates and integrity of his nurse:

> "Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.4.

BEING FAIR

Legal assisted suicide would damage the nursing ethic based on the value *Being Fair* (Justice), enforced by laws requiring equal treatment under the law. Other *amici* will discuss the laws that enforce fairness toward patients in this country. They include the due process and equal protection clauses of the Fifth and Fourteenth Amendments to the Constitution, the Americans with Disabilities Act, and the prohibition against discrimination toward some groups who are more likely to experience pressure to die if assisted suicide were legal.

Amici assert, as detailed above, that the fundamental fairness due nurses under the Fifth Amendment would be violated under legal assisted suicide.

BEING TRUE

Legal assisted suicide would damage the nursing ethic based on the value *Being True* (Loyalty), enforced at a minimum in law by contract law, confidentiality, informed consent, and by law requiring nurses to be advocates for patients. Nursing law mandates that nurses must be advocates for the patient, even if their action is counter to the physician or employer's order.

The changes in nursing practice that legal assisted suicide would force (elaborated above in descriptions of nurse involvement under 1.b.) are severe dislocations of the nurse's ethical and legal duties of loyalty to the patient. Under legal assisted suicide, the nurse's duty to advocate for the patient might become the duty to advocate death for the patient.

LIFE

Legal assisted suicide would damage the nursing ethic based on the value *Life*, enforced by all law that outlaws killing. Though mentioned last, this is the first value of nurses, or the one that underlies all others. The *sine qua non* of nursing ethic is promoting the life of the patient in all aspects, including the comfort of the patient and her value as

an individual. This is so, even and especially as the patient is dying. Promoting and protecting the dying patient's life cannot be subverted to mean assisting her deliberately to kill herself.

At present, the life of the individual is protected by the law, overridden only in extreme circumstances. For example, killing is justified only under narrow conditions such as self-defense, executions, or war.

Under the decisions of the Courts of Appeal, some lives would *not* be protected by law. People who are diagnosed "terminal" would not be protected from assisted suicide. But people who were not dying, *would* be protected from assisted suicide. The assumption underlying that situation: People who are not dying are more valuable than the dying.

Nurses do not discriminate in their care, between patients whose lives are less valued and more valued. This stratification of lives into levels of protection – some more valued, some less valued – is not a new concept. The framers wrote the U.S. Constitution, and courts subsequently have interpreted that Constitution, precisely to *prohibit* laws that classify lives in that way. Yet one of the decisions on review, responding to the state's contention that its principal interest is in preserving the life of all its citizens, answers:

> "[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes."

Quill v. *Vacco*, 80 F.3d at 729 (2d Cir.1996).

b. The national standard of ethics for nurses is that nurses do not assist patients to kill themselves, but threat of legal assisted suicide in one state has caused erosion of that standard.

To state the obvious: The consensus of nursing ethics is that nurses do not assist patients to kill themselves.

The maintenance of the ethical integrity of the professions involved is one of the primary interests Courts weigh in

such cases as these. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980). The court in *Superintendent of Belchertown* took care to find that its decision was in accord with the "prevailing ethical practice" of the profession. The prevailing ethical practice of the nursing profession is *not* to assist patients to deliberate death, evidenced by the following statements of ethics of American nurses.

The American Nurses Association maintains that nurses may not ethically assist suicide (as they would be asked to do under legal assisted suicide):

> "Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments. The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses With Interpretive Statements (Code for Nurses) and the ethical traditions of the profession."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.1.

The national Oncology Nurses Society endorsed the ANA position in 1995. Oncological Nurses Society, *Endorsement of ANA Position Statement on Active Euthanasia and Assisted Suicide* (1995). The American Association of Critical Care Nurses has endorsed as well.

The National Association of Prolife Nurses and its affiliates oppose assisted suicide in the strongest terms, believing it tantamount to euthanasia:

> "The public must be assured that we will not participate in euthanasia or refer people to individuals and organizations supporting euthanasia, and that we consider euthanasia to be medical murder."

Nancy Guilfoy Valko, *National Nurses Group Supports Resistance to Euthanasia*. National Association of Prolife Nurses (1994).

Though addressed to the prohibition against nurses' participation in executions, the following encompasses the ethical standard of the ANA for causing death in patients:

> "Regardless of the personal opinion of the nurse on the moral appropriateness of capital punishment, either generally or specifically, it is a breach of the ethical tradition of nursing, and its Code for Nurses, to participate in taking human life, even through a legally authorized civil or military execution."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The *amici* would add that it is a breach of the ethical tradition of nursing to participate in taking human life, even through a legally authorized nurse assisted suicide as would be possible under legal assisted suicide.

Further nurse ethical standards:

> "The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person."

American Nurses Association, *Code for Nurses* (1986).

The nurse mandate to safeguard the patient from "any person" must include physicians or other nurses who prescribe or administer drugs to cause death.

And yet another ethical standard that nurses must not aid death:

> "Nurses . . . must take all reasonable means to protect and preserve human life when there is hope of recovery or reasonable hope of benefit from life-prolonging treatment. The nurse does not deliberately act to terminate the life of any person."

American Nurses Association, *Code for Nurses with Interpretive Statements* (1986).

As noted above under 1.c., the anticipation of legal assisted suicide in Oregon has resulted in a position statement by the Oregon Nurses Association. That paper admits that nurses would have to participate or assist in their patient's suicide in several ways –

> informing patients of "choices that are legal" (as noted above, to some nurses this would be tantamount to encouraging suicide),
> "providing for ongoing end of life care" for suiciding patients if the patient couldn't be transferred (very likely if the nurse learned of the suicide attempt after the prescription were ingested), and the nurse could make no "judgmental comments or actions because of the patient's choice [to kill himself]," muzzling the nurse's ethical or professional assessment of the patient's choice.

Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995) p. 4 [Material in brackets added]. As can be seen, the threat of legal assisted suicide in Oregon resulted in a position paper from the ONA which copes with that potential reality, by lowering ethical standards to the minimum ethic: Whatever might be made legal is ethical.

In addition to the assault on their professional ethics, many nurses would have personal ethical problems in assisting suicide – though as outlined above and noted under the ONA paper, they would have little choice under legal assisted suicide. Considering the shrinking job market faced currently, nurses would be under great pressure to comply with the employer who requires them to participate with patient suicide.

Some nurses already have been disciplined with job suspension for six weeks for reporting (or for not reporting fast enough – the employer's version) an active euthanasia performed on a child by the physician. *Death at U.C. Med Center,* San Francisco Chronicle, 3 April 1995, A20; *UCSF suspends nurses who delayed reporting incident*, NURSEweek, First April 1995, 3, 20. Under legal assisted suicide, the pressure would increase on the nurse to look away from patient abuse or to lose her job.

Under legal assisted suicide nurses who are religious would face a compromise to the very fundamentals of their morality – encompassed in any version of "Thou shalt not kill." Exodus Chapter 20, Verse 13. Nurses who are not formally religious are no less spiritual, and no less harmed by such an egregious violation of their personal ethic.

Other *amici* will inform the Court of the fact that all medical associations in the world (save Holland's) oppose assisted suicide. They will describe the experience in Holland in which even the tacit legal approval of euthanasia and assisted suicide – far short of the outright legal assisted suicide as proposed by the Courts of Appeal – has become a large problem, for the society, the professions, and most of all the patients of that country.

3. Legal assisted suicide would inculpate nurses in assisting suicide, damaging the profession in the eyes of the public.

a. Under legal assisted suicide, some nurses *would* assist in patient killing.

No illusions may be indulged; under legal assisted suicide, some nurses would be ready, willing and able to assist suicide. Some would kill patients directly if assisted suicide were extended to the disabled who are unable to self-administer the drugs.

The experience of nurses in the 1930's under Germany's National Socialism is instructive. Though some would wish it not so, 1990's American nurses too would be vulnerable to pressures if killing were made legal. Under National Socialism, some nurses and their associations collaborated when Hitler's euthanasia program was legal.

Some German nurses deliberately administered barbiturates to mentally retarded children that they had selected; the children slept for long periods, developed pneumonia as a result, and died a "natural" death. The death certificates read "Pneumonia," but in the consensus of world opinion, ten and now fifty years after, those nurses caused the deaths of those children. *Testimony of Dr. Valentin Falthauser, 22-23 April 1948; and Nurse Mina Worle, 7 May 1948 (Kaufbeuren asylum)*, Heyde Trial, pp. 143-47, in Robert Jay Lifton, *The Nazi Doctors* (1986) p.55.

The nurse associations of Germany collaborated in changing the ethics of the profession to conform to the legal mandates of the National Socialist government. Hilde Steppe,

Nursing in Nazi Germany 14(6) West. J. Nurs. Res. 744 (1992). Some nurses were not, would not be, immune to pressures to eliminate the problem patient instead of eliminating the patient's problem.

b. If legal, future killing would be delegated to nurses.

In addition to the immediate consequences of legal assisted suicide to the profession, the *amici* have reason to worry about their even worse role in the future. Under legal assisted suicide *amici* believe assisted suicide would be extended to actual administration of "suicide" to the disabled and incompetent. Allowing only competent able patients to kill themselves with prescribed drugs inevitably would be held to discriminate against the disabled who can't self-administer the drugs, and against the incompetent who can't request the killing drugs. At that point, prescribing suicide or even direct euthanasia would fall to the nurses as does other dirty work.

In support of that prediction: Technical procedures always are delegated eventually. When blood pressure measurements were first available, only doctors were allowed to perform them. At present, the *amici* are confident that few members of the Court have ever had their blood pressure measured personally by a doctor. When first developed, the technology of intravenous medication was limited to doctors (as late as the 1970s it was not taught in nursing curricula), as was administration of chemotherapy, and virtually all intensive care technology, including interpretation of electrocardiograms.

Today, in various states, nurses can perform all those procedures; in addition, nurse practitioners may set broken bones, suture wounds, and prescribe almost all drugs that physicians can. Under legal assisted suicide, it would be a short matter of time before this last worst "technique" of assisting suicide would be delegated to the nurse.

c. Allowing nurses legally to assist suicide would result in deterioration of the public's trust in their profession.

The public's perception of nurses would change under legal assisted suicide as nurses came to be seen as people who assist with killing. The public would lose confidence in nurses, and would be suspicious of the nurse's intent when she nursed patients labeled "terminal." The social contract that nurses have with the public would be breached. The ANA believes that trust to be essential:

> "Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life. The profession's covenant is to respect and protect human life (Nursing: A Social Policy Statement). Nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession."

Position Statement on Assisted Suicide, p.4.

Assisting in deliberate killing of patients, either by prescribing self-administered medications (nurse practitioners), or by tacitly approving of the patient's decision to die by participating in their care as they suicide – would violate the nurses' social contract with their patients and result in the public's loss of trust in the profession.

If nurses could assist suicide legally, the public's perception of nurses would change. Nurses who could assist in suicide would be seen not as trusted advocates but as people who carry out orders regardless of their effect. They would not be seen as professionals with autonomy and independent judgment, but as lackeys who do the patient's or doctor's bidding no matter how heinous the morality of the order.

Patients would not trust nurses who were handmaidens to physicians prescribing death, and who were unquestioning, "nonjudgmental" servants to any patient with a prescription. At present, the wish to die to the nurse is a cry to help the patient to find reason to live. Under legal assisted suicide, it

would be a mandate to nurse the patient to deliberate death. The public's opinion of nurses could not help but decay.

The nurse's liberty to practice nursing as she knew it and chose it and learned it would be curtailed. Her property interest in working at her profession would deteriorate. Hers then would be a profession with an ethic of promoting or assisting patients to deliberate death, instead of to life.

CONCLUSION

Legal assisted suicide creates an entitlement to assistance with, and approval of, suicide. It inevitably will inculpate nurses in the killing of their patients. It would destroy the public's confidence in the profession of nursing, damaging the nurses' liberty and property rights to practice that profession. It purports to help patients who either do not wish to die (terminal patients, even those in pain) or who are treatable and would be treated if society valued their lives (terminal patients who are depressed and ambivalent). That unwanted, unneeded entitlement is granted to the awful detriment to the fundamental rights of nurses who wish to practice their profession uncorrupted.

Based upon the above, the decisions of the Courts of Appeal should be reversed and the cases remanded for disposition in accordance.

Respectfully submitted,

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APPENDIX

Statements of Interest

This brief *amici curiae* is submitted to the Court by people who will be uniquely and directly affected by the Court's decision in this case. *Amici Curiae* are:

The National Association of Prolife Nurses, nurses who promote and protect the lives of patients at all stages of life, was formed in 1973 with state affiliates and members in all states. Their activities on behalf of patients, and on behalf of nurses who protect patient lives, include legal representation, education, and organization. The members have supported an *amicus* brief to the Ninth Circuit in the case challenging the legalization of assisted suicide in Oregon still pending there.

The National Association of Directors of Nursing Administration in Long Term Care, the managers of facilities where some patients are cared for who would be subject to assisted suicide if legal, was formed in 1986, and has 30 state affiliates with 4000 members from all states. Their code of ethics mandates they support and promote quality of care for those individuals receiving long term care, and concern for those delivering long term care.

The Philippine Nurses Association of America, nurses of Philippine ethnicity who live and work in the U.S., was formed in 1979, and has 25 state affiliates with over 2000 individual members. Their endorsement of the Code of Ethics of the International Council of Nurses mandates they protect, promote and restore health when possible, prevent illness when possible, and alleviate suffering; thus

they believe the legalization of nurse assisted suicide and euthanasia will change the very essence of nursing practice.

The Scholl Institute of Bioethics, a group of professionals in medicine, law, psychology and religon, was established in 1986 because of concern for the increasing difficulty of bioethical decisions that both individuals and the medical profession are facing in relationship to today's modern advances in medicine and the growing euthanasia movement.

California Nurses for Ethical Standards, a non-profit educational and professional organization of nurses who promote in all respects ethical standards of health care, was established ten years ago in the state of California. The members believe that euthanasia and assisted suicide violate all nursing ethics codes.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,
v.
TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON,
Petitioner,
v.
HAROLD GLUCKSBERG, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE AMERICAN GERIATRICS SOCIETY AS AMICUS CURIAE URGING REVERSAL OF THE JUDGMENTS BELOW

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INTEREST OF AMICUS CURIAE [1]

The American Geriatrics Society (AGS) is comprised of professional health care providers focused upon serving the health care needs of elderly persons. Founded in 1942, the AGS has 6,000 dues-paying members. The AGS sponsors conferences and seminars, articulates policy and practice guidelines, publishes a preeminent professional journal (*The Journal of the American Geriatrics Society*), and encourages improved health care services for elderly persons and research on the illnesses from which they suffer. As practitioners specializing in the care of the elderly, AGS members are particularly dedicated to improving how people live at the end of life and consequently have abiding concerns with the issues raised by initiatives to legalize physician-assisted suicide (PAS).

The AGS and its members have worked diligently to assure that even elderly persons with severe dependency and limited personal and family resources can count on reliable and effective diagnosis, treatment, prevention, rehabilitation and supportive care. The AGS has encouraged care providers, the elderly, and their families to adopt an optimistic and energetic approach to treatment of illness. However, geriatricians (including physicians, nurse practitioners, and other health-care professionals) also realize that all elderly persons die, and that serving people well in their old age requires incorporating that fact into judging various strategies for care. Just as we must strive to make available all potentially beneficial treatment, we must also strive to avoid interventions that are more harmful than beneficial.

Legalization of PAS would create a moral dilemma for geriatricians. Most elderly persons experience serious and

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[1] Each party has given its consent, in writing, to the filing of this brief amicus curiae. Their consent letters have been filed with the Clerk of the Court. Counsel gratefully acknowledges the valuable contributions made to this brief by Joanne Lynn, M.D., and Felicia Cohn, Ph.D. Dr. Lynn, a recognized authority on the care of the dying, is a board member of the AGS and chair of its Ethics Committee. Dr. Cohn is associated with Dr. Lynn in the Center to Improve the Care of the Dying.

progressive illness for extended periods before death and need significant social, financial and medical supports.[2] These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs.[3] By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because a patient's relative poverty and disadvantaged social situation is seen as coercive, geriatricians would condemn their patients, and themselves, to live through the patients' undesired difficulties for the time remaining.

This conundrum has prevented defining a defensible role for geriatricians in any legalized practice of PAS. These concerns have driven the members of the AGS to address this issue at a time when few professional organizations have done so. The AGS position statements on PAS and euthanasia are attached.[4] The AGS opposes legalization of PAS at this time. Elderly and frail persons would be put at risk, yet their interests and concerns have not been adequately addressed in the public discussion of these issues.

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[2] Marilyn Moon, *Medicare Now and in the Future* (2nd ed. The Urban Institute Press 1996); *see also* Jack D. McCue M.D., *The Naturalness of Dying*, 273 JAMA 1039-1043 (1995).

[3] Joshua M. Wiener, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance* (1994); Marilyn Moon, *Medicare Now and in the Future* (2d ed. 1996); Carl Eisdorfer et al., eds., *Caring for the Elderly: Reshaping Health Policy* (The Johns Hopkins University Press 1989).

[4] *See* Appendix and AGS Ethics Committee, *The Care of Dying Patients*, 43 J. Am. Geriatrics Soc'y 577-578 (1995); AGS Ethics Committee, *Physician-Assisted Suicide and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995). *See also* Greg A. Sachs, M.D., et al., *Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia*, 43 J. Am. Geriatrics Soc'y. 553-562 (1995).

The AGS urges this Court to note that improving life at its end has only recently become the subject of research and innovation. The potential consequences of accepting or tolerating PAS are unknown. The AGS believes that continued debate on these issues is essential if there is to be wise policy. The AGS takes no position on the merits of PAS for the patients in the cases before the Court. Instead, the AGS urges this Court not to recognize a constitutional right to the practice of PAS. At this time, the Court should exercise restraint in deciding a matter that would be more appropriately left to the states and the people. The AGS adopts the legal argument advanced in the *amicus* brief of the Project on Death in America of the Open Society Institute, which contends that the matter is not yet ripe for constitutional adjudication. The AGS limits this *amicus* brief to a presentation of a medical perspective on the uncertainties that require study and resolution before PAS could be implemented as the policy of any jurisdiction, or recognized as a constitutional right.

SUMMARY OF ARGUMENT

The courts for the Second and Ninth Circuits relied on three serious misperceptions in overturning state laws prohibiting PAS.[5] First, the courts were misinformed as to how people live while dying in the United States. Contrary to the courts' apparent assumptions, the plaintiff-patients in *Quill* and *Compassion in Dying* do not represent the usual situation of persons facing the end of life; severe pain and other symptoms can be relieved for persons near death; and health care generally and at the end of life is undergoing major changes.

Second, the lower courts mistakenly concluded that there is no significant difference between PAS and foregoing life-sustaining treatment. From a medical standpoint, however, clinical, definitional, and procedural considerations reveal important distinctions. These differences add

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[5] *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

to the legal, ethical, and historical distinctions identified by this court in *Cruzan*.[6]

Third, the courts below mistakenly condition their holdings upon the erroneous assumption that six restrictive criteria or safeguards can be easily identified and implemented: that the patients be (a) terminally ill, (b) competent, (c) suffering, (d) acting voluntarily and (e) seeking assistance in obtaining a means of suicide (f) which will be available only from a physician. In fact, as the discussion that follows makes clear, the medical profession has no adequate definitions for some of these criteria and lacks experience with all of them, making it unreasonable to believe that legislatures or courts could easily design procedures to ensure that each criterion could be met and could be sustained.

In view of the misperceptions upon which the decisions below were based, and the dearth of experience and knowledge that would be necessary to implement the exercise of a right to PAS, the AGS respectfully submits that a decision by this Court to constitutionalize PAS would be, at best, seriously premature.

ARGUMENT

I. THE COURTS WERE MISLED BY MISPERCEPTIONS ABOUT END-OF-LIFE EXPERIENCES.

A. The Patient-Plaintiffs Are Not Representative of Dying Persons Generally.

The named patients in the cases before the Court are dying in ways that do not characterize how people generally die in the United States. The identified patients all have a single, well-defined disease: three suffer from AIDS, two from cancer, and one from emphysema. Their situations thus fail to reflect the multiple diseases and uncertain prognoses that are much more common in advanced old age. Patient-plaintiffs' ages average 56 years. Not

[6] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

one of the named plaintiffs is as old as the median age of death in the United States, 77 years.[7] None is characterized as poor, without family, or living in nursing homes. All have physicians, and none mention problems of access due to inadequate health insurance. This sample thus falls far short of representing the array of problems and concerns which should inform a determination of the constitutionality, or even the wisdom, of allowing PAS. The relative simplicity of the medical and social situations of these patients appears to have misled the lower courts into believing that PAS is the only or best response to those patients' problems.

Much has changed about how people come to the end of their lives in the United States. No more than a century ago, dying afflicted every decade of adult life, nearly evenly.[8] The most common causes of death were infections and accidents, which generally allowed little time between onset and death. Even cancer and heart disease were discovered late and the lack of effective treatment meant that death often occurred shortly after diagnosis.

Average life spans have also increased. Now, median life expectancy is 79 for women and 72 for men. Among those who survive to age 65, median age at death is 84 for women and 80 for men.[9] The usual causes of death now include cancer, heart disease, other organ system failures, and dementia, all of which are illnesses that ordinarily cause progressive disability over more than a year.[10] Typically, persons dying in their eighties and older succumb to a combination of loss of reserve capacity in aging

[7] Projection for the year 2000 is 76.7 years. *See* U.S. Bureau of the Census, *Statistical Abstract of the United States: 1995*, 86 (115th ed. 1995).

[8] Council on Scientific Affairs, American Medical Association, *Good Care of the Dying Patient*, 275 JAMA 474-478 (1996).

[9] Reports for 1993 for median life expectancy from birth, and for 1992 for median life expectancy at age 65. *Supra* note 7.

[10] *See* note 8, *supra*.

organs, deficiencies in daily functioning, and diseases with specific etiology.[11]

Modern society must learn how to assure that dependent and disabled persons can live well, despite living for a long time with eventually fatal illnesses. Prognosis is ordinarily uncertain. Poverty and isolation are common. Nearly one in five dies in a nursing home.[12] Depression and other psychiatric problems are common and largely unrecognized.[13] Characterizing the issue as simply acquiescing in the patient's request to end his suffering, as the courts below did, is much more difficult when one imagines a slowly failing elderly widow who is blind, nearly deaf, disabled, and in a Medicaid nursing home, than when the claimant is a younger patient with a predictably fatal illness.

B. Dying Is Mischaracterized as Unavoidably Dreadful.

Contrary to the apparent assumptions of the courts below, fatal illness does not have to mean severe pain and suffering. The Ninth Circuit's opinion repeatedly describes dying as "painful, protracted, and agonizing." [14] The Ninth Circuit then contrasts this fate with death by assisted suicide which lets a patient: "end his life peacefully and with dignity." [15]

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[11] R.R. Kohn, *Cause of Death in Very Old People*, 247 JAMA 2793-2797 (1982).

[12] National Center for Health Statistics, *Vital Statistics of the United States, 1991*, Vol. 2, Mortality, Part A. Sect. 1, Washington, D.C.: Government Printing Office, 1996:380-1. (DHHS publication no. (PHS) 96-1101).

[13] W. Breitbart, *Suicide Risk and Pain in Cancer and AIDS Patients* in: CURRENT AND EMERGING ISSUES IN CANCER PAIN: RESEARCH AND PRACTICE, 49-65 (C.R. Chapman & K.M. Foley 1993).

[14] *Compassion in Dying*, 79 F.3d at 839; *see also id.* at 812.

[15] *Id.* at 824. *See also id.* 814: ". . . a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."

However, most people die quietly, most often in their sleep.[16] Hospice and palliative care programs have demonstrated that no dying person must live with overwhelming pain or other severe physical symptoms. Severe and persistent pain affects about half of cancer patients [17] and one quarter of dying persons generally.[18] Sophisticated palliative care relieves pain for most of these patients without confusion or substantial sedation. Intractable pain that can be relieved only by inducing sedation affilicts less than 3%, mostly very near the end of life.[19] Aggressive palliative care and sedation near death are already permissible. So is the removal of artificial nutrition and hydration [20] that were mentioned as sustaining two of the plaintiff-patients.

However, the standard of care lags behind what is possible to achieve, due both to barriers meant to limit the availability of narcotics and to delay in the adoption of

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[16] D.J. Foley, et al., *Recounts of Elderly Deaths: Endorsements for the Patient Self-Determination Act*, 35 The Gerontologist 119-121 (1995); "I have seen agony in death only once, in a patient with rabies," Lewis Thomas, *The Lives of a Cell* (Bantam Books 1974).

[17] John J. Bonica, *Cancer Pain* in: THE MANAGEMENT OF PAIN, vol. 1, 400-460 (John J. Bonica ed. 1990).

[18] The SUPPORT Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591-1598 (1995).

[19] T.E. Quill, et al., *Assisted Death And Physician-Assisted Suicide* 328 New Eng. J. Med. 965-966 (1993); J. Lynn, *Assisted Death and Physician-Assisted Suicide* 328 New Eng. J. Med. 964 (1993); *see also* R. Melzack, et al., *The Brompton Mixture: Effects On Pain In Cancer Patients*, 115 Can. Med. Ass'n J. 125-129 (1976); J.N. Morris, et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic. Dis. 47-62 (1986).

[20] *Cruzan*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976); *see also* J. Lynn ed., *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Indiana University Press 1989).

better practices by the health care professions.[21] Public policy should more vigorously encourage reliable relief of symptoms, but PAS is never the only option to relieve uncomfortable symptoms in a person near death.

How society arranges services to support care of those at the end of life has profound effects upon how that life can be lived. Life just before death can be especially precious and important. When supported and comfortable, dying persons ordinarily accomplish important tasks, such as saying farewells, disposing of property, completing life projects, and enjoying their remaining days. The courts below do not seem to have taken account of this possibility. *See, e.g., Quill,* 80 F.3d at 729.

Many persons consider suicide or wish for early death while they are angry or suffering. Since persons feeling worthless often test others to see whether these views are shared, encountering agreement actually functions to affirm the denigration of value. To offer PAS at this time does not merely offer an option but also affirms feelings of worthlessness or devaluation.[22] Since, when comfortable and comforted, most patients feel that this was an unexpectedly important time,[23] encouraging supportive care

[21] D.E. Joranson, *Availability of Opioids for Cancer Pain: Recent Trends, Assessment of System Barriers, New World Health Organization Guidelines, and the Risk of Diversion,* 8 J. Pain Symptom Mgmt. 353-360 (1993); *see also* N.J. Cherny, et al., *Opiod Pharmacotherapy in the Management of Cancer Pain: A Survey of Strategies Used by Pain Physicians for the Selection of Analgesic Drugs and Routes of Administration,* 76 Cancer 1283-1293 (1995); World Health Organization, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee.* WHO Technical Report Series, No. 809 (World Health Organization 1990).

[22] "[I]n agreeing to euthanize or assist a patient in suicide, one may be confirming the patient's sense that life has no more meaning or purpose, and this may be the wrong message to convey at such a vulnerable period in the patient's life." Breitbart, *supra* note 13, at 61.

[23] *The Hospice Experiment: An Alternative in Terminal Care* in: THE HOSPICE EXPERIMENT, 1-15 (Vincent Mor, et al., eds., 1988).

and discouraging suicide seems well within the purview of wise public policy.

C. The Lower Courts Misperceived Current Shortcomings in Care at the End of Life as Persistent and Unchanging.

Discussions about PAS are clouded by the paucity of reliable information regarding death in the United States.[24] Nevertheless, this is clearly a time of great ferment. Research in palliative care has developed considerably in the past twenty years.[25] About 61% of Americans die in hospitals and 17% in nursing homes, with the proportion of deaths in nursing homes increasing and those in hospitals decreasing.[26] In 1970, the standard of practice was to attempt resuscitation for virtually every person who died.[27] Now, foregoing life-sustaining treatment is commonplace,[28] especially for those with poor prognoses for survival. Resuscitation is now attempted for only about 10% of seriously ill persons who die in hospitals.[29] In the past, treatments were often continued for patients with poor prognoses and small chances of recovery.[30]

[24] Indeed, the only description of sequential seriously ill patients dying in hospitals in the United States was done in 1904. W. Osler, *Science and Immortality* (The Riverside Press 1904). *See also supra* note 8.

[25] Derek Doyle, et al., eds., *Oxford Textbook of Palliative Medicine,* 4 (Oxford University Press 1993). One recent study of certain seriously ill persons in hospitals has been influential, but it addressed only a small subset of the dying, *supra* note 18.

[26] M.A. Sager, et al., *Changes In Location Of Death After Passage Of Medicare's Prospective Payment System: A National Study,* 320 New Eng. J. Med. 433-439 (1989); *supra* note 12.

[27] Leslie J. Blackhall, *Must We Always Use CPR?* 317 New Eng. J. Med. 1281-1285 (1987); *In re Quinlan,* 355 A.2d 657 (N.J. 1976); Alan Meisel, *The Right to Die* (2d ed. John Wiley & Son 1995).

[28] J.M. Teno, et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for the Seriously Ill Patients?,* 5 J. Clin. Ethics 23-30 (1994).

[29] *Supra* note 18.

[30] E.g., *Cruzan,* 497 U.S. 261.

It is important to consider the major changes that are now reshaping health care generally. The rise of managed or capitated arrangements for service delivery and financing and the shift toward competing on costs rather than quality are rearranging relationships and roles. The impact on end-of-life care is not yet clear, but it is likely to include more reluctance to provide expensive care or to encourage patients and families to seek prolonged survival.[31]

The lower courts accepted a descriptive claim that PAS already exists as a clandestine but widely acknowledged practice.[32] AGS leadership is not familiar with situations in which this is true, and it seems unlikely. Three-quarters of all deaths happen in institutions where a regularized practice would require the collusion of a large number of persons, which seems implausible. Little reliable evidence characterizes the rate and nature of actual instances of PAS.[33] Courts should not rely upon presumptions and unsubstantiated reports in such a matter.

The constitutionality of PAS should not be resolved by reference to atypical situations and reliance upon misperceptions, as happened in these cases. Consideration of the role of PAS must be part of a broader examination of how this society should care for people with fatal illness and is therefore an endeavor more properly undertaken

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[31] S.H. Miles, et al., *End Of Life Treatment In Managed Care. The Potential And The Peril*, 163 West J. Med. 302-305 (1995).

[32] *Compassion in Dying*, 79 F.3d at 801, 828.

[33] All surveys of physician practices or attitudes are of limited validity due to low response rates, biased questions, or potential violations of confidentiality. Some insight is available in: A. L. Back, *Physician-Assisted Suicide And Euthanasia In Washington State. Patient Requests And Physician Response*, 275 JAMA 919-925 (1996); *see also* review of surveys in: K.M. Foley, *Pain, Physician-Assisted Suicide, and Euthanasia*, 4 Pain Forum 163-178 (1995); R. Sean Morrison & Diane E. Meier, *Physician-Assisted Dying: Fashioning Public Policy with an Absence of Data*. Generations 48-53 (Winter 1994).

by state legislatures and professional and lay organizations than by the federal judiciary.

II. THE COURTS BELOW MISTAKENLY CONCLUDED THAT PHYSICIAN ASSISTED SUICIDE IS NO DIFFERENT FROM FOREGOING LIFE-SUSTAINING TREATMENT.

The lower courts erred in finding no justification for distinguishing PAS from foregoing (withdrawing and withholding) life-sustaining treatment (FLST). However, significant medical, legal, and societal distinctions exist between the two practices and fatally undermine the conclusion that they are entitled to the same legal status. The AGS defines PAS as "[w]hen a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life." FLST is defined as "[w]hen medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state."[34] Major American medical associations and public committees and commissions[35] have recognized the distinctions between PAS and FLST.

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[34] AGS Ethics Committee, *PAS and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995), which is printed in the appendix.

[35] *American College of Physicians Ethics Manual*, 3rd ed. 117 Ann. Internal Med. 947-960 at 949 (1992); New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 102 (May 1994); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (March 1983); *see also* The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Indiana University Press 1987); *Guidelines for State Court Decisionmaking in Life-Sustaining Medical Treatment Cases, A Project of the National Center for State Courts* (2d ed., West Publishing Company 1993).

A. Descriptive Aspects Differentiate the Two Situations.

In addition to definitional differences and historical precedent, the situations involving PAS and FLST are associated with important moral and practical differences, including differences in access to medical care, in the practical effects of decisions, and in clinical intent.

Patients wishing to forego treatment are generally already receiving medical attention, and they have life-sustaining treatment available if desired. Thus, FLST decisions are implemented only when the life-sustaining treatment is unwarranted. However, for those seeking PAS, suicide may become a substitute for valuable but inaccessible medical attention. Persons seeking PAS may not know about, nor have available, other options for treatment, whether because of financial need, because their physician has inadequate skills,[36] or because social or ethnic barriers intervene.

Patients receiving life-sustaining treatment are usually very sick and close to death, so that even aggressive intervention is unlikely to lengthen their lives appreciably. With PAS, however, an individual may be giving up a more extended period of life. Fear of suffering and of losing dignity, along with a desire to control circumstances of death, may prompt a request for assistance in suicide before suffering might become unbearable.[37]

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[36] J.H. Von Roenn, et al., *Physician Attitudes and Practice in Cancer Pain Management—A Survey from the Eastern Cooperative Oncology Group*, 119 Ann. Internal Med. 121-126 (1993); *see also* Clive Seale, Ann Cartwright, *The Year Before Death* 186 (Ashgate Publishing Company 1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency* (American Board of Internal Medicine 1996).

[37] Timothy Egan, *As Memory and Music Faded, Oregon Woman Chose Death*, N.Y. Times, June 7, 1990, at A 1:2; *see also* Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 Duquesne L. Rev. 445-455 (1996); *see also* Breitbart, *supra* note 13.

In FLST, the intent is not to bring about the patient's death but to respect the patient's wishes not to be subjected to undesired treatment. Once medical treatment is withdrawn or withheld, the underlying disease process usually leads to the patient's death, though some survive. Although a physician sometimes physically removes the life support, the underlying disease and not the physician's action is ordinarily considered the cause of death. Failure to remove the undesired treatment would amount to battery, an unconsented touching. In PAS, the physician may be acting in accord with the patient's wishes, but death results from a drug overdose rather than a natural course of dying.

The Second Circuit's opinion also appears to suggest that PAS follows from aggressive pain management (80 F.3d at 729). Good pain management, however, usually prolongs life, and even very high doses of opioids rarely cause respiratory depression in patients who have been taking them for more than a few days.[38] Further, good palliative care aims to eliminate the suffering, whereas PAS succeeds only by eliminating the sufferer.

B. Rights Against Interference Are Stronger Claims Than Those for Assistance.

This Court has established that patients have the authority to forego life sustaining treatment, based on the requirement that the patient's informed consent is required for medical intervention.[39] The authority to

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[38] "*Respiratory depression.* This rarely presents a problem if the oral morphine dose is titrated carefully against the patient's pain, for pain is a respiratory stimulant. Tolerance to respiratory depression develops rapidly so that high doses of morphine can be used if necessary, without significant risk." Cicely Saunders et al., *Living with Dying: A Guide to Palliative Care* 23 (3rd ed. Oxford University Press 1995); *see also* American Pain Society, *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 23 (3rd ed. American Pain Society 1992; Marcia Angell, M.D., *The Quality of Mercy*, 306 New Eng. J. Med. 99 (1982).

[39] *Cruzan*, 497 U.S. 261 (1990). *See also In re Quinlan*, 355 A.2d 647 (1976); Mark E Williams, M.D., *The American Geriatrics*

forego life-sustaining treatment is thus a right to prevent unwanted bodily intrusion. Withdrawing or withholding a treatment to honor the patient's refusal of consent is not a matter of providing a patient with assistance but one of leaving the patient alone. Physicians may not impose treatment on a patient who refuses that treatment, even if the physician believes that the treatment will benefit the patient. This right to be left alone does not imply any corollary right to receive a form of assistance such as PAS.

C. The Restriction of Physician Assisted Suicide to a Narrow Class of Persons Highlights Its Differences From Foregoing Life-Sustaining Treatment.

FLST is an option for all treatments and all patients, just like any other medical decision. If PAS were equivalent to FLST, it should be available to all patients. Yet both courts below and all current legislative proposals restrict the right to PAS to a certain category of patients—those that are terminally ill, competent, acting voluntarily, and suffering. Unlike FLST, no proposal allows PAS to be directed in advance or by surrogate decision makers. The uniform agreement on such restrictions clearly suggests that the courts, the legislatures, and the policymakers recognize clear distinctions between PAS and FLST.

D. The History of Familiarity With Foregoing Life-Sustaining Treatment Contrasts Sharply With the Lack of Experience With Physician Assisted Suicide.

As this Court recognized in *Cruzan*, the right to reject life-sustaining medical treatment has had a long history of public acceptance, from legal, ethical, and medical perspectives.[40] Rooted in the common law doctrine of informed consent and recognized by courts, legislatures,

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Society's Complete Guide to Aging & Health, 119 (Harmony Books 1995); *supra* note 34.

[40] *Cruzan*, 497 U.S. 261 (1990); *see also In re Quinlan*, 355 A.2d 647 (1976); *see also* Alan Meisel, *The Right to Die* (2d ed. 1995).

and the health care professions, a consensus has emerged that persons generally have the right to refuse medical interventions, even though death may result.

In sharp contrast, no such consensus surrounds the practice of PAS. It has no common-law basis and has not been recognized widely by courts, legislatures, the public, or the medical profession. Most states have statutes prohibiting the practice of PAS—similar to the New York and Washington statutes struck down by the courts below in these cases. The practice has been approved by the voters in only one state, Oregon, where an initiative passed by a narrow margin but has not yet been implemented. The lack of any substantive experience with PAS, and the myriad restrictions attached to every proposed formulation of a right to request it, show that PAS is considered quite differently by all—its proponents, the law, health care providers, and the public.

III. THE CONSTRAINTS PROPOSED FOR THE PRACTICE OF PHYSICIAN ASSISTED SUICIDE PRESENT INTRACTABLE PROBLEMS.

As noted above, the plaintiffs below sought PAS only for a limited class of persons. Accordingly, the right to assisted suicide recognized in both cases is confined to adult patients who have terminal illnesses; are mentally competent; suffer from chronic and/or severe pain; and make a voluntary request for PAS. In addition, the only authorized method of assistance is through a physician's prescription of lethal medication which the patient must self-administer.

The Second and Ninth Circuits found a constitutional right to PAS conditioned upon these criteria, which they assumed would also function as safeguards to prevent mistakes or abuse. As the discussion below demonstrates, however, those decisions were based upon erroneous assumptions about the feasibility of both defining and applying the eligibility criteria. In fact, if PAS were to be implemented, determining the eligible population

would be intractably difficult and the proposed constraints would likely fail to provide the safeguards upon which the lower courts' decisions were based.

A. Terminal Illness.

Various statutory proposals and the cases before this Court contemplate that PAS will be authorized only for those who are "terminally ill."[41] The opinions below suggest that limiting the category to "terminal illness" helps to make the shortening of life acceptable and presume that the category can be clearly delineated. The Second and Ninth Circuits dismissed arguments asserting the difficulty of determining when a patient is "terminally ill," noting that "terminal illness" and "terminal condition" have been "defined repeatedly . . . in a model statute, the Uniform Rights of the Terminally Ill Act, and in over 40 state natural death statutes."[42] In actuality, such judgments are notoriously difficult to make. Indeed, because terminal illness or terminal condition is so difficult to define, the new Uniform Health-Care Decisions Act,[43] which supersedes the Uniform Rights of the Terminally Ill Act, upon which the Ninth Circuit partially relied, omits any reference to terminal condition

[41] Courtney Campbell, et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Center Report 36-43 (May-June 1995); Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 333 Harvard Journal on Legislation 1-34 (Winter 1996); Oregon Death with Dignity Act, Ballot Measure 16 (passed Nov. 8, 1994); *Quill*, 80 F.3d at 731; *Compassion in Dying*, 79 F.3d at 838.

[42] "[W]hile defining the term 'terminally ill' is not free from difficulty, the experience of the states has proved that the class of terminally ill is neither indefinable nor undefined," *Compassion in Dying*, 79 F.3d at 831. *See also Quill*, 80 F.3d at 731 (stating that "it seems clear that most physicians would agree" on when the condition of "final stages" of terminal illness occurs).

[43] Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws at its conference held July 30-August 6, 1993, and approved by the American Bar Association on February 7, 1994.

and does not attempt to define terminal illness. The reasons for this omission have been explained as follows by David English, the reporter for this new Uniform Act: "Most existing advance directive legislation becomes effective only if a patient is in a 'terminal condition,' or is 'permanently' unconscious. Such restrictions have severely limited the usefulness of many state statutes and, indeed, have rendered them virtual nullities."[44]

As the drafters of this new Uniform Act thus recognized, terminal illness is notoriously difficult to define, and the working definitions of "terminal illness" for hospice or advance directive legislation are neither relevant nor reassuring, as the courts below erroneously concluded.

Hospice programs, for example, enroll mostly persons with some particular cancers.[45] Referral to hospice is most often initiated when such a patient experiences a deterioration in function, weight and comfort, usually three to six weeks ahead of death.[46] For cancer, then, the clinical course dictates timing, which is much shorter than the hospice statutory prognosis requirement of six months. Other illnesses do not regularly have such a final, relatively distinct, phase of clinical deterioration and they are engendering problems when referred into hospice.[47]

[44] See English and Meisel, *Uniform Health-Care Decision Act Gives New Guidance*, 21 Estate Planning 355, 359 (1994).

[45] N.A. Christakis & J.J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172-178 (1996).

[46] J. Lynn, *Caring At The End Of Our Lives*, 335 New Eng. J. Med. 201-202 (1996); J.N. Morris et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic Dis. 47-62 (1986).

[47] Hospice programs are being scrutinized by the Dept. of Health and Human Services' Office of the Inspector General, with disagreements on prognosis as hospice expands to enroll patients dying of chronic diseases. J.G. Brown, *Review Of Medicare Hospice Beneficiary Eligibility In The Commonwealth Of Puerto Rico* (DHHS, OIG, March 1996). *See also* Standards and Accreditation Commit-

A more rigorous definition of terminal illness seems necessary for PAS, since PAS has such significant and irreversible consequences. Three general approaches might be used in attempting to define the category "terminally ill": subjective judgment, statistical criteria, or a disease severity threshold. An examination of each of these reveals crippling problems.

1. *Subjective Determination.*

Some person or persons could be designated to judge whether a patient is "terminally ill," using information about the patient's situation, prognosis, care needs, and preferences. At present, the patient, family, and professional caregivers negotiate the designation while discussing plans and making decisions. The label then marks a change from a strategy of correcting abnormalities with the expectation of long survival to a strategy focusing on function, comfort, and emotional and spiritual support with the expectation of death.

In routine patient care, the timing of this change in focus does not much matter. The various participants can arrive at the designation at somewhat different times. However, the obvious variation in and diffuseness of this process would be troubling in the context of determining eligibility for authorizing PAS, and the fact that availability of PAS would be contingent on a designation of being terminally ill may result in pressure to accelerate or resist the label.

2. *Statistical Determination.*

Defining terminal illness with an explicit statistical threshold seems to offer clarity: a person is either below or above that threshold. However, this approach fails as it encounters at least four serious barriers.

First, the data necessary to calculate estimates which can be compared with a legislated statistical threshold is

tee, Medical Guidelines Task Force, *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases* (2d ed. National Hospice Organization 1996).

only rarely available. Very little research addresses the issue.[48] Most people will die of conditions that are not predictable with a statistical model.[49]

Second, the threshold is unavoidably arbitrary, with many borderline cases and unavoidable errors of over-inclusion and underinclusion. Any threshold will include people who will live a long time; the rate increases with more inclusive thresholds. A population in which each person has exactly a 25% chance to live six months will have one in four persons still alive at six months. The threshold should include all who will soon die of a serious chronic disease. However, some diseases are intrinsically unpredictable, even very close to death.[50] No reason justifies setting the threshold at any particular point, thus rendering any threshold arbitrary and subject to dispute.

Third, any specific threshold is inconsistent with current usage of the category. The popular conception of "termi-

[48] APACHE III and similar systems estimate the risks of dying during a particular hospitalization for very seriously ill patients in hospital intensive care units. W.A. Knaus et al., *The APACHE III Prognostic System. Risk Prediction of Hospital Mortality for Critically Ill Hospitalized Adults*, 100 Chest 1619-1636 (1991). SUPPORT's formula allows estimation of survival throughout the ensuing six months, but only for certain seriously ill patients with nine specific diseases, treated in hospitals. W.A. Knaus, *et al.*, *The SUPPORT Prognostic Model: Objective Estimates of Survival for Seriously Ill Hospitalized Adults*, 122 Ann. Internal Med. 191-203 (1995). Other available formulae are even more restricted in population, setting, or data required.

[49] The estimate varies also because other predictions can arise from one research database.

[50] Prognoses are surprisingly optimistic very near to death. Lung cancer patients in one study had a median prognosis of 17% to live two months on the day before death, and 50% just one week before death. Those dying of congestive heart failure, however, had a prognosis of more than 60% to live two months, and more than 40% to live six months, on the day before death. So, any criterion requiring less than a 50-50 chance to live two months would exclude virtually all of those who die with congestive heart failure. J. Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311-336 (1996).

nal illness" mainly deals with cancer, neurological degenerative disease, and AIDS patients, all persons who have no available treatment, are losing weight and function, and who are psychologically "ready" to die. Most persons dying of chronic organ system failure will be excluded with a restrictive threshold and many persons with substantial opportunities for treatment and prolonged survival will be encompassed within an inclusive threshold.[51]

Fourth, the prognosis for survival can depend upon patient and physician choice and availability of treatment. A person with diabetes could stop insulin, a person with a feeding tube could stop its use, or a person with heart disease could be refused for transplant. If thereby such a person becomes "terminally ill," then the category is disquietingly dependent upon volitional actions rather than patient status.

Thus, defining the category of terminal illness with a statistical threshold would be arbitrary and certain to overinclude and underinclude substantial populations.

3. *Disease Threshold.*

The third way to define "terminal illness" ties the classification to clinically significant and morally important events, such as the recurrence of cancer in a distant site or the onset of fecal incontinence in a demented person.

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[51] *Id.* Half of all persons who die of lung cancer today will have had a prognosis of better than 30% to live 2 months, just one week ago, so any more restrictive threshold will miss most persons dying of lung cancer. Conversely, such a threshold will include many persons with acute respiratory, cardiac, or liver failure, who usually are vigorously treated. In fact, they qualify for transplantation only when they become so severely ill. If the category were expanded to include everyone with up to a 50% chance to live six months, most nursing home residents would qualify. If the category were restricted to those with a 1% chance to live two months, not only would one exclude virtually all cancer patients but those in the category would be so sick that they would, on average, die within a day. *See also* J.M. Teno, et al., *Prognosis-Based Futility Guidelines: Does Anyone Win?*, 42 J. Am. Geriatrics Soc'y 1202-1207 (1994).

However, an individual's status is not well characterized by the extent of one serious disease. Rather, a person's future is shaped by a variety of illnesses; reserve capacity of various organs; social situation; personal preferences; and treatment availability, use, and response. Thus, many of the patients included will actually have long expected life spans. This method is also afflicted with problems described above with regard to a statistical criterion.

Thus, no approach to defining terminal illness offers a simple and feasible method for determining who should have access to PAS. The problems appear to be intractable and no experience yet shows that they can be overcome.

Finally, even if terminal illness could be satisfactorily defined, it would not last long as a restriction on PAS. The courts below held, for example, that there are no differences between PAS and FLST. If that were true, requiring terminal illness would eventually be dropped, since there is no such requirement for FLST.

B. Competence.

Another criterion, upon which the right to PAS recognized by the courts below is contingent, is competency at the time the request for PAS is made and implemented. This criterion is also problematic. Classifying competence is difficult and sometimes impossible. In addition, the requirement raises troubling questions about PAS, since it may induce patients to choose suicide preemptively, in order to preclude losing the option through a subsequent deterioration in their mental faculties. Furthermore, the competence requirement interacts with the requirement for being terminally ill, since patients tend to lose competence as illness becomes more severe.

Although a variety of legal and medical decisions are predicated on a finding of competency, there is no uniform standard or set of procedures for making this deter-

mination.[52] In practice, such judgments typically are made by health care professionals, in consultation with family members, and may be influenced by many factors, including the purpose of the evaluation. No professional discussion yet addresses appropriate competence standards for PAS, what components of cognitive and emotional functioning should be measured, or how capable the person must be in each component (or all taken together) in order to qualify for PAS.

The seriously ill commonly have deficits in cognitive and emotional functioning which change over relatively short periods of time and correlate strongly with suicide inquiries. Many elderly patients and dying cancer patients experience delirium, a syndrome in which they are confused, unable to maintain attention, and unable to master new information.[53] Most episodes are not detected in usual care. Likewise, depression is common, serious, and often undetected and untreated.[54] Depression, delirium, and mood disorders strongly correlate with suicide. Indeed, most cancer patients now committing suicide have discernible psychiatric illness, and having such an illness corresponds strongly with risk of suicide.[55] Treatment of depression substantially alters an initial inclination to refuse life-sustaining treatment.[56] Excluding these patients from access to PAS would be essential, but that turns

[52] Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities To Consent To Treatment*, 319 New Eng. J. Med. 1635-1638 (1988).

[53] J. Francis, et al., *A Prospective Study Of Delirum In Hospitalized Elderly*, 263 JAMA 1097-1101 (1990); William Brietbart, et al., *Neuropsychiatric Syndromes and Psychological Symptoms in Patients with Advanced Cancer*, 10 J. Pain Symptom Mgmt. 131-141 (1995).

[54] Brietbart et al., *supra* note 53.

[55] Breitbart, *supra* note 13.

[56] Linda Ganzini, *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 Am. J. Psychiatry 1631-1636 (1994).

out to be quite difficult. Most depression, just like most delirium, is not recognized or treated in current practice.[57] The risks of involving persons with diminished capacity in PAS are substantial. Furthermore, a narrow definition of terminal illness will yield high rates of incompetence while a broader definition will yield high rates of long survival.

Moreover, as suggested above, a special problem with a lengthy dying process is fear of the indignity associated with incompetence.[58] If the right to PAS extends only to those with contemporaneous competence, then patients with conditions likely to lead to incompetence may find it appealing to undertake preemptive suicide. This is a special risk in early dementia, when patients retain ability to understand but have failing memory. The rate of progression to cognitive disability is unpredictable. Thus dementia patients hoping to avoid the worst-case scenario may be sacrificing many comfortable and relatively capable years when they seek PAS preemptively.

C. Undue Influence—Coercion.

1. *The Context of Care.*

Proponents of a constitutional right to PAS expect the practice to be limited to persons who are acting voluntarily, without undue influence or coercion. The image is that of an independent, capable person thoughtfully evaluating his or her options, unaffected by biased third parties or other circumstances. This is so far from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions, and vulnerable to the suggestions, expectations, and guidance of others. In this context, pressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient's in-

[57] S.R. Rapp, et al., *Detecting Depression In Elderly Medical Inpatients*, 56 J. Consult. Clin. Psychol. 509-513 (1988).

[58] *Supra* note 8; *supra* note 13; *see also* P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669-674 (1991).

dependent judgment and thus amount to inappropriate coercion.[59]

The health care available to the terminally ill may be the most important factor influencing the care provided and may result in requests for PAS that could be avoided if appropriate care were available. Large variations in whether people die at home or in a hospital in various regions of the country are strongly related to hospital bed supply and regional hospice investment, and not to preferences, wealth, family presence, or other patient characteristics.[60]

2. *Financial Considerations.*

Patients nearing death are generally quite disabled and their care is costly. While hospital and physician costs decline past the age of 70, long-term care costs rise, and these are mostly borne privately.[61]

The plaintiff-patients in the cases below do not appear to have been burdened with economic difficulties. Yet, economic influences are among the most important in defining a population eligible for PAS. One-quarter of those over 65 are below 150% of the Federal poverty level, and institutional long-term care has become largely a poverty program under Medicaid.[62] As pressures increase to curtail health care expenses, hospital admissions are limited and hospitalizations are shortened. Decreasing availability and increasing expense in health care and the

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[59] H.M. Chocinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185-1190 (1995).

[60] R. Pritchard, et al., *Regional Variation in the Place of Death*, 9 J. Gen Internal Med. 146a (1994); *see also* The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care* (AHA Publishing 1996).

[61] A Scitovsky, "*The High Cost of Dying Revisited*," 72 Milbank Mem. Fund. Q. Health Soc. 561-591 (1994).

[62] *Id.; see also* Marilyn Moon, *Medicare Now and in the Future* (1996).

uncertain impact of managed care may intensify pressure to choose PAS.

Should financial pressures be considered undue influence or not? This is the special dilemma of those who serve the frail, disabled, and poor. The AGS's concern is that PAS may become inherently coercive in a society in which supportive services and medical care are often unavailable. It would be ironic, indeed, to have a constitutional right to PAS when there is no guarantee of access to health care.

D. Suffering.

The courts below also appear to assume that the right to PAS may be reliably limited to persons who are suffering or in pain. Medical practice has no consensus on how to define or measure such a state. Most patients can be physically comfortable without sedation, and sedation can always eliminate symptoms in persons near death. This course is available at present, without any change in the law, and thus precludes a requirement that the patient must have symptoms that cannot be relieved. While some may view such treatment as undesirable, it is difficult to see why death through PAS should be considered a distinctly better (and constitutionally dictated) policy option.

E. Physician Involvement.

There is little reason to believe that physicians now have expertise in modes of killing, yet all proposals for PAS mandate physician participation. Although the counseling skills and prescription-writing privileges of physicians might at first blush suggest that their involvement in PAS is appropriate, this Court should recognize the practical difficulties this requirement imposes upon medical caregivers. There is no drug approved as safe and effective and therefore no drug legally available for PAS,[63] no in-

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[63] In a recent survey of Oregon physicians who would be eligible to prescribe under the 'Death with Dignity Act,' 50% of respondents

struction is given in medical texts,[64] and practice standards show pervasive inattention to counseling and symptom management for those near death. Physicians are usually required to inform patients of alternatives which might be advantageous. No proposal has exempted PAS, but the implications of having to broach this subject with seriously ill persons have not been considered in the discussions to date. The potential for engendering distrust and diminishing effectiveness in physician-patient encounters may justify not engaging physicians in this work. Without experience, recognizing a right to commit suicide through the assistance of physicians is clearly premature.

F. The Scope of Assistance.

The constitutional right to PAS articulated by the courts below limits the physician's aid to prescribing medications in lethal doses. Clinical experience suggests that this limit is untenable and will inevitably lead to demands for more active physician involvement in bringing about the patient's death.

If a physician were to prescribe medication in a dose which should be sufficient to cause death, the rulings below require that the patient seeking PAS actually ingest the drugs and do not provide for any further assistance by the physician. Very likely, patients will sometimes take too little of the drug, will be more resistant than expected, or might vomit and lose much of what was ingested. Determining the appropriate response to a partial overdose in the context of legal, assisted suicide would pose difficult problems for physicians, family members, or friends, since survival with brain damage and incompetence could result.

Such difficulties seem likely to lead to pressure to allow intravenous administration of lethal drugs, both because

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said they did not know what to prescribe for PAS. M.A. Lee, et al., *Legalizing Assisted Suicide - Views of Physicians in Oregon*, 334 New Eng. J. Med. 310-315 (1996).

[64] A. Carron, et al., *What is Taught About Care for the Dying in Three General Medicine Texts?*, 44 J. Am. Geriatrics Soc'y, 533 (1996).

they are more reliable and because they bring about death without apparent symptoms, such as prolonged respiratory distress, that might be difficult for family members or attendants to witness. Limiting the scope of physician assistance to the prescription of lethal drugs is thus unlikely to be sustainable. The experiences of physician assisted death in The Netherlands suggest that a progression from patient self-administration of lethal medication to physician assistance with intravenous routes is a likely consequence of allowing PAS.[65]

In summary, the criteria delimiting the boundaries of the constitutional right to PAS found by the courts below are inherently unstable, difficult or impossible to define, and probably incapable of application at the present time. Without the benefit of further experience, there simply is no way of knowing whether this society could accommodate the exercise of a constitutional right dependent on these eligibility criteria.

IV. THE COURT SHOULD VACATE THE ORDERS OF THE LOWER COURTS.

This Court should reverse the opinions of the lower courts, and decline to recognize a constitutional right to PAS for a limited class of persons at the end of life. This is clearly an issue that is not ripe for consideration by this Court now. We explicitly adopt the legal argument for this position as presented by the Project on Death in America in an *amicus* brief filed in these cases.[66]

As explained above, no jurisdiction in the United States has yet had any experience with the practice that, it is contended, should be recognized as a fundamental right. The AGS has been opposed to legalizing PAS or physician involvement in euthanasia, primarily on the grounds that

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[65] P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669 (1991).

[66] *See also* Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 Duquesne L. Rev. 159-181 (1996).

our frail elderly patients are especially vulnerable to social coercion and that the well-being of those who are old and sick is not being carefully considered in the legislative and judicial discussion of this issue.

This is a very dynamic time with regard to care at the end of life. Only in the last few decades has living past the eighth decade become commonplace, and only recently has dying become a slow process in the setting of progressive chronic disease. New findings about what can be done with regard to relieving symptoms and supporting dying persons and their families are being reported regularly. States continue to debate both their support of the poor and their willingness to allow PAS. This is a time to enhance our understanding of how to care for dying patients, not a time to foreclose further learning by precluding innovation and evaluation.

Instead, we believe that the issue should be left to institutions more able to fashion flexible resolutions, with the benefit of further study and debate, such as state legislatures, the health care professions, and community organizations.

In this connection, we note that, should the Court agree with the Petitioners' arguments that the New York and Washington statutes do not violate the 14th Amendmen, then the 10th Amendment could provide an additional constitutional framework for reversal.[67] Since the Constitution neither delegates to the federal government the power to regulate PAS, nor prohibits its regulation by "the States, [such power is] reserved to the States respectively, or to the people."[68]

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[67] *See New York v. United States*, 505 U.S. 144, 157 (1992) ("The question is not what power the Federal Government ought to have but what powers in fact have been given by the [States and] the people." (*quoting United States v. Butler*, 297 U.S. 1, 63 (1936)); *see also Mugler v. Kansas*, 123 U.S. 623, 664 (1887).

[68] U.S. Const. amend. X; *see also U.S. Term Limits v. Thornton*, 115 S. Ct. 1842, 1876 (1995) (Thomas, J., dissenting); *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 546 (1985) ("The essence of our federal system is that within the realm of authority left open to them under the Constitution, the States must be equally free to engage in any activity that their citizens choose for the common weal, no matter how unorthodox or unnecessary anyone else —including the judiciary—deems state involvement to be.")

CONCLUSION

For the foregoing reasons, the judgments of the United States Courts of Appeals for the Second and Ninth Circuits should be reversed.

Respectfully submited,

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APPENDIX

APPENDIX

POSITION STATEMENT

Physician-Assisted Suicide and
Voluntary Active Euthanasia

AGS Ethics Committee *

BACKGROUND

The American Geriatrics Society has previously issued a statement on Voluntary Active Euthanasia (VAE). The public debate on this subject has broadened to include Physician-Assisted Suicide (PAS) and reflects the concern of many individuals about control over the terminal phase of their lives. The Society has affirmed that patients have the authority to choose among available plans of care, but their autonomy is limited when there are substantial detrimental effects on the lives of others or their choices conflict with legal or professional standards. (*See* AGS position statement, "Medical Treatment Decisions Concerning Elderly Persons"). Advocates of extending legal and professional standards to include VAE and PAS believe it is the patient's right to choose deliberately to end his or her life, under circumstances of intolerable suffering, when that individual reasonably and voluntarily prefers death to the life that confronts him or her.

DEFINITION OF TERMS

Physician-Assisted Suicide

When a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life.

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* Prepared by Margaret Drickamer, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, November 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

Voluntary Active Euthanasia

When, at the request of the patient, a physician administers a medication or treatment, the sole intent of which is to end the patient's life.

Withholding or Withdrawing Treatment

When a medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state.

POSITION

1. For patients whose quality of life has become so poor as to make continued existence less preferable than death, the professional standard of care should be that of aggressive palliation, not that of intentional termination of life. It is morally acceptable for a physician to administer a medication with the intent of treating a symptom, knowing that the medication may have the unintended effect of hastening the patient's death. This approach may include the withholding or withdrawing of any medical intervention as well as the specific palliation of symptoms, even if this advances the moment of death. The patient's request for death should trigger the physician's thorough exploration and understanding of the patient's suffering and the reason the request is being made at that particular time.
2. Patients for whom these issues are relevant should be informed of two important facts: a. Profound pain can be relieved with analgesia or sedation, and b. Patients may choose to forgo any life-prolonging intervention, including artificial nutrition and hydration. Because these issues are often misunderstood, the physicians have the responsibility to inform their patients of these alternatives.
3. Laws prohibiting VAE and PAS should not be changed. In giving a patient the means to palliate his

or her symptoms, a physician may inadvertently provide the means for suicide (e.g., by prescribing necessary but potentially lethal medications). The law should differentiate between this situation and the intentional participation in the planning and execution of a suicide. Laws in many states remain very vague as to the extent to which the physician's participation is considered to be a breach of the law. The definition and legal status of PAS should be further clarified.

4. If PAS or VAE are legal in any jurisdiction, the AGS contends that the strongest protection for patients to make a choice free of coercion should be in place and that it should be illegal for professional caregivers to receive financial compensation for assisting in suicide or euthanasia.

RATIONALE FOR CONTINUED PROHIBITION

1. Historically, the fundamental goal of the doctor/patient relationship has been to comfort and to cure. To change the physician's role to one in which comfort includes the intentional termination of life is to alter this alliance and could undermine the trust between physician and patient.
2. Allowing for VAE and PAS (especially in view of the possibility for its use in Advance Directives where patients are no longer competent and their directives are subject to interpretation) opens the door for abuse of the frail, disabled, and economically disadvantaged of society.
3. It is the general consensus of the AGS that most individuals who consider PAS or VAE do so out of fear of the dying process. The vast majority of patients can be appropriately palliated (including the use of general sedation) and would choose this alternative if they had full confidence that the medical profession would do so. A thorough search for the

underlying reason for the request for death may uncover several areas amenable to potential interventions (e.g., undertreated physical symptoms, psychosocial or spiritual crisis, clinical depression, etc.).

4. Legalization of physician-assisted suicide might thwart society's resolve to expand services and resources aimed at caring for the terminally ill, dying patient.

RECOGNITION OF THE CONSEQUENCES OF CONTINUED PROHIBITION

1. By prohibiting physicians from participating in VAE or PAS, we are limiting the patient's autonomy to choose his or her mode of death. For a patient who has intractable suffering and a limited life span, who has turned down general sedation, and who wishes to avail him- or herself of the choice to plan or execute their own demise, we must withhold our professional assistance.
2. Knowing that a small number of patients will choose this alternative despite our professional nonparticipation, the AGS recognizes that its members may choose not to give professional support to the patient in this decision.

FUTURE DEBATE

The medical profession, as well as society as a whole, is continuing to address this issue. We encourage this continued debate as the physician's role in the care of the dying patient is further defined.

POSITION STATEMENT

The Care of Dying Patients: A Position Statement from the American Geriatrics Society

AGS Ethics Committee *

BACKGROUND

Dying is the final portion of the life cycle for all of us. Providing excellent, humane care to patients near the end of life, when curative means are either no longer possible or no longer desired by the patient, is an essential part of medicine. The American Geriatrics Society (AGS) recognizes that most people near the end of life desire and should be able to obtain attentive and effective care directed at relieving symptoms, maximizing comfort, and maintaining dignity and control. Providing excellent care to dying patients and their families is time consuming and requires expertise as well as compassion. Care of patients who are dying is more than just withholding burdensome treatments; it is the provision of a special form of medical care, one in which physicians can take pride and find fulfillment. Making such care regularly available will require improvements in systems for service delivery and in professional education.

DEFINITIONS

Patients Who are Dying

Within this document, people are considered to be dying when they have a progressive illness that is expected to end in death and for which there is no treatment that can substantially alter the outcome. Thus, people are dying when they have illnesses such as advanced dementia

* Prepared by Greg A. Sachs, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, May 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

or severe congestive heart failure, in addition to illnesses more routinely recognized as terminal, such as advanced cancer. Care of dying patients also encompasses patients who have elected to forgo available treatments that might forestall death, such as dialysis for end stage renal disease.

Palliative Care

Within this document, palliative care, also referred to as comfort care, refers to care directed toward the quality of life of patients who are dying, including the relief of pain and other symptoms, attention to the psychological and spiritual needs of the patient, and providing support for the dying patient's family.

PATIENT CARE ISSUES

Position 1

The care of the dying patient, like all medical care, should be guided by the values and preferences of the individual patient.

Rationale

Optimal medical care of all patients, not just those who are dying, rests on frank and sensitive communication between patients and physicians. For dying patients, this ordinarily entails recognition and discussion of the facts surrounding prognosis and the likely course with a palliative plan of care. The conversations throughout must continue to elicit and respond to the patient's needs. When the patient loses decision-making capacity, care should be guided by these previous conversations as well as by written advance directives, if available.

Position 2

Palliative care of dying patients is an interdisciplinary undertaking that attends to the needs of both patient and family.

Rationale

In caring for dying patients, physicians must themselves develop a broad array of knowledge and skills and an attentiveness to comprehensive care. In addition, whether or not the patient is enrolled in a formal hospice program, physicians most often should function as members of a team. The team may include nurses, social workers, homemakers, home health aides, physical therapists, chaplains, volunteers, and the patient's family. Each team member contributes the special knowledge and the skills of his or her discipline to help meet the needs of dying patients. Together, team members provide care for the patient and assist the family in coping with the patient's dying and death. Family members (with "family" defined by the individual patient) usually play a critical role in both providing care for dying patients and in making decisions for dying patients who have lost decision-making capacity. Providing support for the patient's family, including a period after the patient dies, is an important aspect of the palliative care of dying patients.

Position 3.

Care for dying patients should focus on the relief of symptoms, not limited to pain, and should be addressed by both pharmacologic and nonpharmacologic means.

Rationale

Pain, anxiety, depression, dyspnea, constipation, and other symptoms can all be significantly ameliorated, if not eliminated, in the vast majority of dying patients, provided we employ fully our pharmacologic armamentarium and appropriate nonpharmacologic interventions. Symptoms should be treated vigorously, even if the unintended effect of these efforts is the hastening of death. Though not medical symptoms, dignity and control are central issues for many dying patients.

HEALTH CARE DELIVERY ISSUES

Position 4

Dying patients should be guaranteed access to comprehensive, interdisciplinary palliative care across the spectrum of care settings as part of any federal or state health care reform plan, without care being conditioned on the financial status of the patient.

Rationale

Palliative care is often provided most appropriately in the patient's own home, a setting where reimbursement is inadequate under many existing insurance plans. Dying patients should be able to receive palliative care in the home, the hospital, and the nursing home, depending on the needs and preferences of the patient, without a disruption in the continuity of the patient's care.

Position 5

Reimbursement policies should be modified to enhance the availability of palliative care.

Rationale

Patients and families are presently faced with major financial obstacles to choosing palliative care, while payment for continued highly technological, acute care (e.g., dialysis, ventilator care, etc.) is readily available. Physician reimbursement should also be modified to promote palliative care. Like other forms of primary care, palliative care is time consuming, does not involve highly reimbursed procedures, and requires substantial counseling of patients and families.

Position 6

Administrative and regulatory burdens that may serve as barriers to palliative care should be reduced.

Rationale

Currently, hospices providing care for dying patients face special administrative burdens in addition to the usual paperwork facing all health care institutions. Requirements regarding availability of family and a home for caregiving regularly prevent some patients from receiving palliative care through hospices. Uncertain or unavailable estimates of prognosis also may serve inappropriately to exclude patients in need of palliative care services. Regulations intended to promote adequate nutrition for nursing home residents and laws intended to prevent assisted suicide and euthanasia should be written or revised so that these issues are not confused with proper palliative care decisions and treatment.

EDUCATION ISSUES

Position 7

Physicians, as well as other health care professionals, at all levels of training should receive concrete, insightful, and culturally sensitive instruction in the optimal care of dying patients.

Rationale

Medical students and physicians in training in the United States today rarely receive specific and in-depth instruction on the care of dying patients. This instruction should address attitudes toward and reactions to death and care of the dying, symptom management (especially pain control and adequate use of narcotic analgesics), and communication skills. The importance of knowledge about the care of dying patients should be reinforced by evaluating it on board exams and other specialty certification exams.

Position 8

The public, including our patients and our colleagues, needs to be educated regarding the availability of pallia-

tive care as an important and desirable option for dying patients.

Rationale

It is the position of AGS that this kind of educational effort would benefit many by dispelling the notion that the only options available to dying patients are continued futile therapy in a medical setting or turning to assisted suicide or euthanasia (see related AGS position statement).

RESEARCH ISSUES

Position 9

Adequate funding for research on the optimal care of dying patients should be provided.

Rationale

Much of the information base needed to inform patients and physicians regarding optimal care of dying patients does not yet exist. Studies documenting the outcomes of various types of care plans, medications, and treatment settings, especially ones focused on the experience of the dying patient, should take place. Although traditional biomedical research on symptom relief is needed, much of what is already known about symptom relief is not implemented effectively because of professional ethical concerns about aggressive symptom management and institutional barriers to the provision of palliative care. Research on these matters, including educational approaches and interventions to promote palliative care, is needed.

Supreme Court, U.S.
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In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, *et al.*

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*

Respondents.

On Writ of Certiorari to the U.S. Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, *et al.*

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*

Respondents.

On Writ of Certiorari to the U.S. Court of Appeals for the Ninth Circuit

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BRIEF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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42 pp

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QUESTIONS PRESENTED

(1) Is there a Fourteenth Amendment substantive due process right to obtain a physician's assistance in committing suicide?

(2) Are patients who refuse or withdraw consent to life-sustaining treatment similarly situated to patients who request that a physician prescribe or administer a lethal dose of medication?

(3) Does the state have a sufficiently important interest in prohibiting the consensual killing of patients by physicians to outweigh any purported right to assistance in suicide?

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BRIEF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS*

INTEREST OF THE AMICUS CURIAE

The Catholic Health Association of the United States ("CHA") represents over 1200 Catholic sponsored health care facilities and organizations that serve millions of people each year.

Catholic health care organizations understand their mission to be far more than simply the delivery of a social good. "Catholic sponsored health ministry, like the church itself, must not only proclaim the gospel but commit to transform the social order according to gospel norms" of love and justice. National Coalition on Catholic Health Ministry, *Catholic Health Ministry in Transition* 4 (1995). This ministry is rooted in and informed by a deeply held commitment to promote and defend human life and human dignity.

CHA's interest in this case stems from its concern for the need to protect vulnerable persons; to insure appropriate care for dying persons; to preserve the integrity of the health care profession; to strengthen the bonds of community; and also to preserve the integrity of Catholic health ministry.

A body of moral principles developed over centuries informs Catholic teaching on health care matters. These moral principles likewise inform the National Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* (1995) ("*Directives*"), which provide guidance to Catholic health professionals on a range of economic, technological, social and moral challenges. For instance, Catholic health care is required to support patients

* Consents to the filing of this brief have been lodged with the clerk.

and their families who must face the reality of death. *Directives* at 21.

Furthermore, the *Directives* guide Catholic health ministry in its advocacy efforts:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: * * * the elderly; [and] those with incurable diseases * * *. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

Id. at 7.

Assisted suicide offends the most basic moral precepts of our culture and, in particular, poses a grave danger to those "at the margins of our society." In fulfilment of its mission, the *amicus* urges this Court to reverse the Courts of Appeals.

SUMMARY OF ARGUMENT

The Ninth Circuit partial *en banc* opinion in *Compassion in Dying v. Washington* (Wash. Pet. App. A-1 to A-117), positing a substantive due process right to physician-assisted suicide, is based on two fundamental misconceptions: first, that this Court's abortion jurisprudence stands for the proposition that any "private" or "intimate" decision by a citizen is entitled to protection under the Due Process Clause; and second, that an instruction to a physician to withdraw life-sustaining treatment, which this Court assumed to merit constitutional protection in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), is equivalent to a request for a physician's assistance in suicide.

The Second Circuit's opinion in *Quill v. Vacco* (N.Y. Pet. App. 1a-62a), likewise erroneously equates a person's

negative right to refuse unwanted treatment with a positive right to be assisted in suicide, holding that New York's permission of the former and prohibition of the latter violates the Equal Protection Clause. The court could see no rational basis for making such a distinction.

Nothing in the Constitution or this Court's jurisprudence entitles citizens to request that a physician prescribe or administer the means to kill. The States of Washington and New York have the duty to protect the lives of their citizens from the consequences of legalized assisted suicide. Similarly, these states have the obligation to protect the fiduciary relationship between doctor and patient, upon which the integrity of the medical profession depends. Once health care professionals are permitted to "assist" people in killing themselves, our society's rationally constructed bright line prohibiting private killing will be obliterated.

ARGUMENT

The courts below seek to create a new constitutional right to assisted suicide based primarily on their fallacious equating of assisted suicide with the withdrawal of treatment. This fundamental error is at odds with our legal and cultural tradition.

As a starting point, we look to the example of Joseph Cardinal Bernardin, Archbishop of Chicago, who announced in October 1996 that he had decided not to continue chemotherapy for his cancer. S. Kloehn, "Bernardin Ends Cancer Care/Chemotherapy Hasn't Reduced Tumor Size," Chi. Trib., Oct. 18, 1996, at 1. In his letter to this Court, Cardinal Bernardin states, "I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention." App., *infra*, 1a. Where life-sustaining interventions are deemed ineffective or

disproportionately burdensome, even in the case of a person on a ventilator, the intervention may be removed. Whether deciding to discontinue chemotherapy or to remove a ventilator, the absence of an intent to kill distinguishes these acts from one in which a person intends to take his own life. Such an act is suicide. Facilitating such an act is assisted suicide.

I. THE DUE PROCESS CLAUSE DOES NOT GUARANTEE A RIGHT TO OBTAIN A PHYSICIAN'S ASSISTANCE IN COMMITTING SUICIDE.

In a sweeping act of positive lawmaking, the Ninth Circuit attempts to create a new substantive due process right to assisted suicide. This Court should not endorse such a dramatic departure from its precedent and from the Nation's legal and moral traditions.

A. The Washington Statute Bans Homicide, Not "Hastening One's Death."

Suicide is "[t]he act of killing oneself intentionally." *Webster's II: New Riverside Dictionary* (1984). Catholic teaching has consistently recognized the difference between killing oneself (suicide) and withholding or withdrawing disproportionate means to sustain life.[1]

However, the Ninth Circuit asks not whether there is a right to be assisted in "killing oneself intentionally," but whether there is a liberty interest in "determining the time and manner of" or "hastening one's death." Wash. Pet. App. A-29. The court's oblique declaration of the constitutional "right" it creates allows it to sweep into the discussion "a whole range of acts that are generally not considered to

[1] "Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden * * *." *Directives* at 22-23.

constitute 'suicide[]' [including] * * * the act of refusing or terminating unwanted medical treatment." *Id.* Indeed, in a total subversion of the English language, the court states that it has "serious doubts that the terms 'suicide' and 'assisted suicide' are appropriate legal descriptions of the specific conduct at issue here." *Id.*

The court's use of words is more than mere semantics. The newly proposed right is quite broad. There is no coherent way to limit a purported right to "assisted suicide" to terminally ill people or to competent people who can communicate. Once the Court affords terminally ill citizens the "right" to have a physician assist them in suicide, it will have to afford such a right at least to all competent adults for, according to the Ninth Circuit, the right is grounded not in the terminal illness, but in the right to determine the time and manner of one's death. Moreover, there is nothing to limit this right to patient-administered medication; the lower courts' reasoning would appear to apply just as readily to those seeking euthanasia (*i.e.*, physician-administered lethal medication). Of course, the Ninth Circuit dismisses this fundamental concern, "consider[ing] it less important who administers the medication than who determines whether the terminally ill person's life shall end." Wash. Pet. App. A-100 to A-101.

Once all competent adults have such a right, the right would have to be extended to incompetent adults, for incompetent persons do not lose their constitutional freedoms simply due to their incompetence. *See* Wash. Pet. App. A-159 (Beezer, J., dissenting). The only issue would be whether and how a surrogate can act for an incompetent person. *E.g., Cruzan, supra*. Once incompetent people have the right to assisted suicide (whether or not they are terminally ill), advocates for mature or emancipated minors, and for the legal representatives of minors would urge the extension of the right to them as well. *Cf. Planned Parenthood v. Casey*, 505 U.S. 833, 970-71 (1992); *City of Akron*

v. Akron Center for Reproductive Health, 462 U.S. 416 (1983); *Bellotti v. Baird*, 443 U.S. 622 (1979).

In addition, once this Court recognizes a Substantive Due Process right of physician-assisted suicide, even for healthy adults, it will face the compelling argument of those who do not need a physician's help to commit suicide, but only wish the help of a friend or trusted family member. The purported right to assisted suicide is based on the belief that the law may not prevent a person from ending his own life, and thus that a state may not interfere with the efforts of those who would assist in such an endeavor. There is no implicit limitation in such a right to the assistance of physicians; in theory, a person entitled to "hasten their death" should be able to accept the help of anyone. At this point, assisted suicide is no longer a clinical event occurring in a health care setting; it is nothing more than state-sanctioned killing by private agreement.

B. The Court Should Not Create A New "Right" To Assisted Suicide That Lacks Any Basis In The Text Of The Constitution Or The History And Tradition Of Our Nation.

The Ninth Circuit begins (Wash. Pet. App. A-31 to A-32) by dutifully reciting the standard expressed in what it calls this Court's "highly controversial" opinion in *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986) (citations omitted):

> Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection. In *Palko v. Connecticut*, it was said that this category includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were

> sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland*, where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition."

Unfortunately, the Court of Appeals ignores this standard, all but disregarding the long history and tradition in this country of prohibiting consensual killing. Indeed, the court proceeds to survey "current societal attitudes," citing polls showing public support for "the prerogative [of patients] to accelerate their death by refusing or terminating treatment" and for assisted suicide and euthanasia. Wash. Pet. App. A-48. Relying on its understanding of "our unwritten history" and its own knowledge, the court concludes that suicide and assisted suicide are actually accepted practices in society, justifying enshrining them in the pantheon of constitutionally protected activities which may not be proscribed by legislation. *See id.* at A-51 to A-52.

An accurate reading of the American legal tradition reveals something much different. It demonstrates a consistency between our society's historical rejection of assisted suicide and Catholic teaching. Moreover, Church teaching has been influential in shaping the societal views and practices which inform this Court's due process analysis.[2]

From the earliest times, the Church has condemned

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[2] Catholic teaching has historically been a major force in the development of Western thought. R.J. Araujo, "Thomas Aquinas: Prudence, Justice, and the Law," 40 Loy. L. Rev. 897, 913-915, 921 (1995); G. N. Herlitz, "The Meaning of the Term 'Prima Facie,'" 55 La. L. Rev. 391, 391 n.5 (1994). On end-of-life issues, courts have referred freely to historical Catholic teachings in their examination of this society's moral traditions. *E.g.*, Wash. Pet. App. A-131 to A-134 (Beezer, J., dissenting); *In re Quinlan*, 355 A.2d 647, 659-60 (N.J.), *cert. denied* 429 U.S. 922 (1976).

suicide.[3] Two figures in the Church's history stand out in this regard. St. Augustine of Hippo (354-430) articulated the principles on which Christianity condemned suicide by arguing that the prohibition against killing applies to all persons, including oneself. St. Augustine, *City of God*, Book I, ch 20. Building upon that foundation, St. Thomas Aquinas (c.1225-1273) further explained the reasoning behind the prohibition, arguing that suicide is contrary to the natural inclination that persons love themselves, that suicide injures the community, and that God alone has the power over life and death. St. Thomas Aquinas, *Summa Theologica II-II*, Q. 64, art. 5. Significantly, Aquinas also argued that suicide is an offense because it is an act of injustice against the community.

In this century, the Second Vatican Council reiterated the Church's powerful opposition to suicide:

> The varieties of crime [against the human person] are numerous: all offenses against life itself, such as murder, genocide, abortion, euthanasia and wilful *suicide* * * * all these and the like are criminal: they poison civilization; and they debase the perpetrators more than the victims and militate against the honor of the creator.

"Pastoral Constitution on the Church in the Modern World" (*Gaudium et spes*), *Vatican Council II*, at 926 (A. Flannery, ed. 1992) (emphasis added).

More recently, the Vatican reiterated the Church's opposition to suicide:

> Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on

[3] *E.g.*, the Council of Arles (452), the Council of Braga (563), the Antisidor Council (590) and the Synod of Nimes (1274). T. Marzen, M. O'Dowd, D. Crone & T. Balch, "Suicide: A Constitutional Right?" 24 Duquesne L. Rev. 1, 57, 60 (1985).

> the part of a person is to be considered as a rejection of God's sovereignty and loving plan.

Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 7 (1980). *See also Directives* at 21 ("Suicide and euthanasia are never morally acceptable options").

Most recently, the *Catechism of the Catholic Church* emphasizes the broad social consequences of killing oneself. Suicide "offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations." United States Catholic Conference, *Catechism of the Catholic Church* § 2281, at 550 (1994). In sum, the Catholic tradition's aversion to suicide is so strong that the American Bishops insist that those associated with the Catholic health care ministry neither condone nor participate in assisted suicide. *Directives* at 23.

Our own legal tradition has also consistently condemned suicide, and thus assisted suicide. Henry de Bracton's 1220 treatise and Sir Edward Coke's 1644 treatise, *Third Institute of the Law of England,* identified the common law crime of suicide and its severe property penalties. *See* T. Marzen, M. O'Dowd, D. Crone & T. Balch, Suicide: A Constitutional Right?" 24 Duquesne L. Rev. 1, 57, 60 (1985). In *Hales v. Petit*, 75 Eng. Rep. 387 (1561-62), the English Court applied sanctions against suicide. In the United States, *Massachusetts Commonwealth v. Bowen*, 13 Mass. 356 (1816), illustrates the early American common law prohibition against assisted suicide. The fact that states later abolished criminal penalties for unilateral suicide does not reflect societal approval of these acts. "These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those who committed or who attempted to commit the act were thought to be prompted by mental illness." Y. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" 23 *Hastings*

Center Report 32, 41 (1993). Indeed, the common law, and in many instances state statutes, prohibited suicide and assisted suicide both at the time of the Revolution and at the time the Fourteenth Amendment was ratified. *See* Wash. Pet. App. A-44 to A-46; *Cruzan*, 497 U.S. at 294 (Scalia, J., concurring), citing Marzen, *et al.*, *supra*. In fact, notwithstanding the Ninth Circuit's research into popular opinion, all but one state today prohibits assisted suicide. *See* Wash. Pet. App. A-48 to A-49.

Because our moral tradition and our law has so uniformly condemned these practices, it is simply inaccurate to say that the right to assist in committing a suicide is a "liberty" that is "deeply rooted in this Nation's history and tradition," or that is "implicit in the concept of ordered liberty." Indeed, it is our proud history to have prohibited such dangerous conduct.

C. This Court's Decisions In *Casey* And *Cruzan* Do Not Protect Consensual Killing Or Assisted Suicide.

The Ninth Circuit relies on *Casey* and *Cruzan* for the unsupportable proposition that there is a liberty interest in "hastening death" which the state may not burden. Neither *Casey* nor *Cruzan*, however, can support the creation of this expansive right. Although in both cases this Court applied a balancing test to state restrictions on actual or assumed liberty interests (the same test the Ninth Circuit purports to apply), the finding of liberty interests in *Casey* and *Cruzan* was itself subject to the larger principles enunciated in *Bowers* and prior cases.

1. *Casey*

According to the Ninth Circuit, *Planned Parenthood v. Casey* requires the conclusion that there is a liberty interest in assisted suicide because "the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity

and autonomy.'" Wash. Pet. App. A-57 (quoting *Casey*).

The language in *Casey* about highly personal and intimate decisions cannot be taken out of context to support the awesome breadth of the Ninth Circuit's pronouncement.[4] The Court did not say that *any* intimate decision of importance to the individual ought to be treated as a liberty interest. Many such decisions not only lack constitutional protection, but are in fact proscribed by law:

> Those adjectives might be applied, for example, to homosexual sodomy, polygamy, adult incest, *and suicide*, all of which are equally 'intimate' and 'deep[ly] personal' decisions involving 'personal autonomy and bodily integrity,' and all of which can constitutionally be proscribed because it is our unquestionable constitutional tradition that they are proscribable.

Casey, 505 U.S. at 984 (Scalia, J.) (emphasis added). Suicide—and *a fortiori*, assisted suicide—have long been proscribed, and are not entitled to constitutional protection regardless of their "intimate" or "personal" nature. *Cf.* Bernardin, infra, 1a-2a (assisted suicide not merely a personal matter because it harms society).

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[4] The Court's decision in *Casey* was heavily influenced by the doctrine of stare decisis, leading certain members of the Court to recognize a liberty interest in having an abortion in deference to *Roe v. Wade*, 410 U.S. 113 (1973), even if they might not have done so in the first instance. 505 U.S. at 853. Thus, the Court set the case apart: "Abortion is a unique act * * *. [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Id.* "[O]ne could classify *Roe [v. Wade]* as *sui generis*." *Id.* at 857 (plurality). *Accord id.* at 952 (Rehnquist, C.J., concurring and dissenting). Indeed, "because *Roe*'s scope is confined by the fact of its concern with postconception *potential* life, * * * any error in *Roe* is unlikely to have serious ramifications in future cases." *Id.* at 859 (emphasis added). The abortion precedents are simply not applicable in other contexts, and cannot provide a basis for extending "privacy" or "liberty" to assisted suicide.

2. *Cruzan*

The Ninth Circuit next cites this Court's decision in *Cruzan* to support its creation of a constitutional right to "hasten death." Wash. Pet. App. A-62. In *Cruzan*, the Court assumed that a patient would have the right to refuse or terminate life-sustaining medical treatment, but held that the state had the right to insist on strict safeguards in cases involving incompetent persons. Accordingly, the Court upheld Missouri's "clear and convincing" standard for proof of an incompetent individual's wishes. 497 U.S. at 284.

Cruzan did not recognize any generalized "right to die," let alone a right to assisted suicide. On the contrary, the Court explicitly noted with approval the fact that assisted suicide was *illegal* under state law:

> States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, *the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide*.

497 U.S. at 280 (emphasis added).

Despite this clear language and the expressly narrow grounds of this Court's decision, the Ninth Circuit used *Cruzan* as a springboard to an expansive "right" heretofore unknown to the law:

> *Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, *necessarily* recognizes a liberty interest in hastening one's own death.

Wash. Pet. App. A-62 (emphasis added). To appreciate the magnitude of the lower court's illogical leap from the actual *Cruzan* holding, the Court need look no further than at how the *Cruzan* Court reached its decision.

The Court began with a discussion of the doctrine of

informed consent at common law. 497 U.S. at 269 ("[the] notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment"). As the Court noted, "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 270. *See also id.* at 277 ("As these [state law] cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment"). This was not anything so broad as a right to "privacy,"[5] but rather the right to be free of compelled surgical intrusions. *E.g.*, *Cruzan*, 497 U.S. at 287-289 (O'Connor, J., concurring):

> Requiring a competent adult to endure [forced medical treatment] against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

The right assumed to exist in *Cruzan* is thus firmly rooted in the jurisprudence of battery, not some inchoate right to control human destiny in all respects. *Cruzan* does not govern this case.

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[5] *E.g.*, *Cruzan*, 497 U.S. at 279 n.7:
Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional, right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest. See *Bowers v. Hardwick*, 478 U.S. 186, 194-195 (1986).

II. THE EQUAL PROTECTION CLAUSE DOES NOT GUARANTEE THE RIGHT TO ASSISTANCE IN SUICIDE.

As the Second Circuit observes, the Equal Protection Clause "simply requires the states to treat in a similar manner all individuals who are similarly situated." N.Y. Pet. App. 20a. "The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is 'rationally related to a legitimate state interest.'" *Id.* at 21a, quoting *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985).

The Second Circuit struck New York's statutes criminalizing assisted suicide under the Equal Protection Clause on the ground that:

> New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths [and] the distinctions made by New York law with regard to such persons do not further any legitimate state purpose.

N.Y. Pet. App. 24a. The court acknowledged that the statute fell "within the category of social welfare legislation and [was] therefore subject to rational basis scrutiny upon judicial review" but could see no "legitimate state purpose" to distinguish between persons who withhold or withdraw their consent for life-sustaining treatment and persons who wish to have physicians assist them in killing themselves. *Id.* at 24a-25a.

A. The Law Regarding Assisted Suicide And Discontinuation Of Treatment Applies Equally To All.

The Second Circuit errs in subjecting New York's legislation to judicial review because New York does not discriminate between "similarly situated" individuals at all. In New York, as almost everywhere, a patient has the right to refuse or discontinue unwanted medical treatment. *See*

N.Y. Pub. Health Law § 2892. As noted in Section I, *supra*, this right derives from the doctrine of informed consent, and is grounded in the Constitution's protection of bodily integrity. *See Cruzan*, 497 U.S. at 277. Arguably, a physician who does not respect this right is guilty of at least a civil battery. *Id.* at 269.

On the other hand, in New York, as almost everywhere, it is illegal to aid or abet a suicide, or to kill another person, even where the individuals involved are a physician and a patient. N.Y. Penal Law §§ 125.15(3), 120.30. *See also Cruzan*, 497 U.S. at 290-291 nn.2-4 (O'Connor, J., concurring) (collecting various state laws). The Court of Appeals equates revocation of consent to life-sustaining treatment and assisted suicide because they both result in the death of the patient. *See Cruzan*, 497 U.S. at 280. "But constitutional law does not work that way." *Cruzan*, 497 U.S. at 286.[6]

For one thing, patients in each example seek to employ vastly different means to their respective ends, and it is those means which New York treats differently. As did the Ninth Circuit, the Second Circuit ignores this, adopting instead the imprecise and misleading descriptor that both patients are "hastening their deaths." N.Y. Pet. App. 29a-30a. One can equate virtually any two situations by defining the terms broadly enough, but that is not the purpose of the Equal Protection Clause. *E.g.*, *Kelley v. Johnson*, 425 U.S. 238 (1976) (right of bodily autonomy does not include right to control personal appearance at the workplace).

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[6] The assertion that different courses of conduct are equivalent simply because they cause the same result is absurd. Accidents, self defense and murder all cause deaths. Abortion and feticide both kill fetuses. Illegal drugs and alcohol both cause intoxication. The law treats all of these matters differently because they all involve different conduct. Of course, the source of the Ninth Circuit's confusion is that it improperly identifies the effect (*i.e.*, causing death) as the right assumed in *Cruzan* instead of the means (*i.e.*, withdrawal of life-sustaining treatment). *Cf.* Bernardin, App., *infra*, 1a-2a.

Indeed, New York's ban on assisted suicide is a neutral, generally applicable body of law that proscribes conduct; it does not apply unequally to different classes of people. New York does not purport to prohibit "hastening one's own death." New York prohibits aiding and abetting a suicide.

It is true that under New York's scheme some people end up with more control over the precise timing of their deaths than others, but that is not the fault of the law. It is simply due to the biological fact that certain people will die without medical intervention while others will not. The important point for Equal Protection purposes, however, is that both classes of people have precisely the same legal rights and are subject to precisely the same legal prohibitions: the right to refuse or withdraw treatment (regardless of the expected outcome), and the prohibition against aiding and abetting suicide. The fact that results arising from the exercise of the right and from the impact of the prohibition vary with the individual is not only permissible, it is to be expected in any society made up of unique individuals. *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (Equal Protection Clause does not guarantee identical outcomes, just equal treatment under law).

B. Assisted Suicide Is Morally Distinguishable From Forgoing Life-Sustaining Treatment And Pain Management, Both Of Which May Hasten Death.

1. Discontinuation of Treatment and Hastening Death.

In Catholic teaching, assisted suicide is nothing less than killing. The dignity of the human person is not promoted through acts which destroy life. There is thus an important distinction between suicide and the choice to forgo disproportionate life-sustaining treatment.

Cardinal Bernardin is "at the end of [his] earthly life." App., *infra*, 1a. His decision to discontinue chemotherapy will probably hasten his death. Similarly, a decision to forgo

disproportionate life-sustaining treatment (though the person may die) does not necessarily entail an intention to kill. Both decisions are consistent with Church teaching on due proportion in the use of remedies. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 11-12 (1980). As noted in the *Directives* (at 21):

> We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome.

2. Pain Management And Hastening Death.

In the course of treatment, patients often require increasing doses of medications like morphine to control their pain. In seeking to control pain, the prescribing physician runs the risk of depressing respiration, and thus while trying to manage pain, hastening death. A. Hardie, "Morphine Drip has Little Opposition," *Atlanta Const.*, Mar. 8, 1995, at C3; L. Lamberg, "Treating Depression in Medical Conditions May Improve Quality of Life," 276 JAMA 857 (1996). In such circumstances, there is no intention to kill the patient. Death is not the object of the act. Nor is "hastening death" the *means* used to relieve pain, even though death may be forseen.

The practice of prescribing effective pain relief that may, at the same time, hasten death as a forseen yet unintended consequence is supported by both the medical profession and Catholic teaching:

> Medications capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death.

Directives at 23; *cf. Declaration on Euthanasia*, *supra*, at 7-9; Pius XII, *Address* of 24 February 1957: *Acta Apostolicae Sedis* 49, at 147. *See also* Kathleen M. Foley,

"Pain, Physician-assisted Suicide, and Euthanasia," 4 *Pain Forum* 163, 164 (1995).

This analysis is consistent with the principle of double effect, Thomas O'Donnell, *Medicine and Christian Morality* 29 (1976), as understood in both the Catholic moral tradition and the medical profession. *E.g.*, D. Gianelli, "Assisted Suicide or Pain Relief?" *Am. Med. News*, July 1, 1996, at 3; D. Wintersheimer, "The Role of Courts in Terminating Nutrition and Hydration for Incompetent Patients," 10 *Issues in L. & Med.* 453, 457 (1995). Moreover, it points out the fallacious reasoning of the Ninth Circuit, which concedes its lack of appreciation for the concept:

> More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. * * * To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.

Wash. Pet. App. A-82.

Of course, in the case of palliative care and forgoing disproportionate life-sustaining treatment "the intended result" is *not* death, but the alleviation of pain or burden. The fact that killing and withdrawal of treatment might both "hasten death" does not render them morally equivalent.

Accordingly, those who forgo life-sustaining medical interventions and those who seek a fatal dose of medication from a physician are not "similarly situated." Physicians respecting the right of a patient to refuse life-sustaining treatment are not similarly situated to physicians who comply with a patient's request for the means to accomplish a fatal

drug overdose. Statutory schemes permitting the former and prohibiting the latter simply reflect society's respect for bodily integrity and its condemnation of homicide. As such, they are not subject to judicial review under the Equal Protection Clause.

III. THE GOVERNMENT HAS A PARAMOUNT INTEREST IN PREVENTING THE KILLING OF HUMAN BEINGS THAT (1) OUTWEIGHS ANY PURPORTED LIBERTY INTEREST IN RECEIVING AID FROM A PHYSICIAN TO KILL ONESELF, AND (2) JUSTIFIES TREATING ASSISTED SUICIDE DIFFERENTLY FROM THE WITHDRAWAL OF LIFE-SUSTAINING TREATMENT.

Even if the Court were to find that there is a liberty interest in "hastening one's death" by assisted suicide, or that those seeking to "hasten death" by forgoing life-sustaining treatment and by assisted suicide are "similarly situated," the government may still prohibit assisted suicide if it can demonstrate a sufficient interest in doing so. For Equal Protection purposes, the state need only show a rational basis for the legislation. N.Y. Pet. App. 21a. For Due Process purposes, a balancing test may be employed. *E.g.*, Wash. Pet. App. A-22. In either case, the Washington and New York statutes should be upheld because those states have a compelling interest in prohibiting assisted suicide, sufficient to outweigh any purported liberty interest in private consensual killing, and sufficient to justify distinguishing between revocation of consent to life-sustaining treatment and receiving physician assistance in killing oneself.

A. Preserving Life.

The Ninth Circuit accurately describes the state's unqualified interest in preserving life:

> [T]he State may assert an unqualified interest in preserving life in general. As the Court said in *Cruzan*,

> "we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life * * *." *Cruzan*, 497 U.S. at 282. Thus the state may assert its interest in preserving life in all cases, including those of terminally ill, competent adults who wish to hasten their deaths.

Wash. Pet. App. A-65. Unfortunately, the court then ignores its own observation, concluding that Washington does *not* have an interest in preserving life simply because, like most states, it permits patients to refuse or revoke consent for life-sustaining medical treatment. *Id.* The Second Circuit employs essentially the same argument. *See* N.Y. Pet. App. 32a.

This approach is flawed in two ways. First, it simply begs the question of whether forgoing life-sustaining treatment can be equated with aiding a person in committing suicide. As demonstrated above, it cannot. Washington and New York do not value life any less simply because their citizens have the right to be free from non-consensual touchings. *See* RCW 70.122.010 (basing right to withdraw treatment on the right to individual autonomy); N.Y. Pub. Health Law § 2892 (codifying state common law to same effect).

Second, after paying lip service to the principle that "'a state may properly decline to make judgments about the "quality of life" that a particular individual may enjoy,'" the Ninth Circuit employs the most dangerous form of utilitarian reasoning, unjustifiably devaluing the lives of terminally ill persons: "When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling." Wash. Pet. App. A-72. The Second Circuit is even more blunt (N.Y. Pet. App. 31a) (emphasis added):

> [W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes * * *. What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life" * * *? The greatly reduced interest of the state in preserving life compels the answer to these questions: *"None."*

Both courts below have fallen into the same conceptual trap. They have looked to language in *Casey* and in this Court's other abortion cases which weigh against the rights of the woman, the variable state interest in protecting the life of a fetus, a state interest which this Court has found to vary with the fetus' increasing "potentiality" for life. *See Casey*, 505 U.S. at 869-73.[7] These precedents are totally inapposite, notwithstanding the fact that they do accord "potential life" at least some weight in the balance. *See Casey*, 505 U.S. at 871 (abortion may be restricted after viability).

In the case of assisted suicide, the value of life is not subject to a sliding scale. There is no disputing the status of terminally ill persons: they are persons at all times and for all constitutional purposes, and their lives have as much value and meaning as the life of any other person. *See Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (striking statute permitting physician assisted suicide by terminally ill persons because it denied them equal protection of the law). Thus, Washington and New York each have a paramount interest

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[7] Of course, this Court's entire abortion discussion proceeds from the assumption that the fetus is something less than a "person" recognized at law. *See Casey*, 505 U.S. at 982 (Scalia, J., concurring and dissenting). The CHA does not agree with the Court's conclusion, nor with its approach to statutes restricting or prohibiting abortion, but the Court's devaluation of the life of the fetus in abortion cases is still distinguishable from this case, involving other living persons.

in preserving life, and in ensuring equal protection of the law for all lives, including the lives of those who are terminally ill.

B. Preventing Suicide.

Washington and New York have decided that suicide is so dangerous to their citizens and to the social order that it ought to be a crime to aid or abet a person attempting to kill themselves. As shown above, these states are not alone, for suicide and assisted suicide have traditionally been prohibited. *See* Wash. Pet. App. A-39 to A-47; N.Y. Pet. App. 18a-19a; Section I.B, *supra*. Indeed, under most states' laws, those contemplating suicide are *per se* subject to involuntary commitment, and citizens have a privilege to interfere with anyone attempting to commit suicide. *Cruzan*, 497 U.S. at 298 (Scalia, J., concurring).

Neither Court of Appeals disputes the state's legitimate interest in preventing suicide. Instead, both courts apply the same flawed reasoning to this interest as they do to the state's interest in preserving life. In both cases, the courts below devalue the lives of terminally ill persons simply because they express a wish to die and are going to die anyway. However, the state's interest in preventing suicide does not diminish simply because a suicidal person "wants" to die.[8]

C. Protecting The Integrity Of The Medical Profession, Especially In A Managed Care Environment.

The state also has an important interest in protecting the integrity of the medical profession or, as Judge Noonan put it, denying to physicians "the role of killers of their

---

[8] Of course, everyone who attempts suicide *claims* to "want" to die. However, as the Ninth Circuit admits, "[s]tudies show that many suicides are committed by people who are suffering from treatable mental disorders." Wash. Pet. App. A-73.

patients." *See Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995), *vacated*, 79 F.3d 790 (9th Cir. 1996)(*en banc*). *See also* Edmund D. Pellegrino & David C. Thomasma, *For the Patient's Good* 205-206 (1988); Edmund D. Pellegrino & David C. Thomasma, *A Philosophical Basis of Medical Practice* (1981). The courts below dismiss this by simply assuming that states will adopt safeguards to protect patients, but the states' power to adopt safeguards does not lessen their interest in the first instance in seeking the most effective way to guard against the perversion of the role of a physician. Similarly, a health care environment dominated by managed care might create economic incentives which the state must properly offset through criminal legislation.

In response to the dramatic rise in health care expenditures, cost-conscious insurers have increasingly adopted principles of managed care. AMA, Council on Ethical & Judicial Affairs, "Ethical Issues in Managed Care," 273 JAMA 330 (1995). Managed care plans' techniques to control provider costs include fixed per-patient payments, restricted treatment options and financial incentives to promote efficient care. *Id.* The most tightly managed plans pay fixed sums for enrolling a patient. The amount of the provider's payment, therefore, is not dependent on whether services are rendered to the patient.

Managed care can serve many legitimate health policy purposes. Yet, managed care requirements can place physicians and other providers in situations rife with difficult ethical concerns. The needs of patients can conflict with the financial interests of providers. *Id.* at 331. In managed care settings, providers often accept some financial risk in the treatment of their patients. This risk may be substantial when treating terminally ill patients who often require expensive treatment. In addition, the economic incentives of managed care can be structured so as to inappropriately reward minimum treatment and the shortest possible hospital

stays. *Cf.*, Newborns' and Mothers' Health Protection Act of 1996, P.L. 104-204, 1996 HR 3666, 110 Stat. 2874, 2935 (Sept. 26, 1996) (requiring health plans offering childbirth benefits to provide minimum inpatient coverage for at least 49 hours following vaginal deliveries and 96 hours following cesarean sections). Health care providers feel these economic pressures. Porter Storey, M.D., medical director of the Texas Medical Center's hospice in Houston has stated "[t]he [financial] incentives in managed care make euthanasia the most cost-effective choice." R. Sorelle, "Fear of Pain," Hous. Chron., Oct. 21, 1996, at 1.

Providing constitutional protection for physician-assisted suicide would provide a new treatment "option" for patients. In order to satisfy the doctrine of informed consent, a physician could be legally obligated to disclose an "option" to physician-assisted suicide to terminally ill patients. *See* Barry R. Furrow, *et al.*, *Health Law* § 6-11(e), at 424 (1995). *See also* Patient Self-Determination Act, 42 U.S.C. §§ 1395cc(f)(1)(A)(i)-(ii), 1396a(w)(1)(A)(i)-(ii) (hospitals must inform patients of state law health care rights). Due to the financial incentives inherent in managed care, the physician could benefit financially from a patient's decision to commit suicide. This development may place a physician in a serious dilemma between the ethical constraint to "do no harm" and the ability to gain financially should the patient choose the now "legitimate" treatment option of physician-assisted suicide.[9] Of course, rather than trusting their providers, patients will then have to question the providers' motivations to discern the most appropriate course of treatment.

Recognizing a right to assisted suicide also raises a host

[9] The physician's hippocratic oath states "[I will] abstain from whatever is deleterious and mischievious. I will give no deadly medicine to anyone if asked, nor suggest any such counsel." AMA, *The Health Care Almanac* 120 (1995).

of difficult questions for health care providers which were dismissed by the lower courts as mere regulatory matters. Wash. Pet. App. A-102 to A-104; N.Y. Pet. App. 34a n.4. What if the physician morally objects to assisted suicide? Must hospitals which institutionally object to assisted suicide (*e.g.*, Catholic hospitals) be required to cooperate in the performance of such a procedure or allow physicians on staff who perform these acts? *Cf.* Directive 60 (App. B). How must payors cover assisted suicide costs? These are not merely hypothetical questions. *E.g.*, *Lee*, 891 F. Supp. 1429.

Recognizing a "right" to physician-assisted suicide will subvert the integrity of the medical profession. States not only have an important interest, but a compelling reason, to protect their citizens from abuses and to protect the integrity of the health care profession.

D. Preventing Abuse.

The state can and should prevent the involvement of third parties in so grave a matter as suicide. Even if suicide itself is not illegal, allowing others to take part in the process will increase the risk of abuse, and expose vulnerable patients to family and financial pressures from which they should be insulated.[10]

The state also has an interest, as it always has when enacting criminal legislation, in avoiding the adverse consequences anticipated from the actions it seeks to prohibit. *E.g.*, *People v. Kevorkian*, 210 Mich. App. 601, 534

[10] The Ninth Circuit acknowledges the risk of these pressures, but appears unconcerned:

> we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration [in requesting assistance in committing suicide].

Wash. Pet. App. A-87.

N.W.2d 172, 175 (1995)(Dr. Kevorkian's "actions implicate the criminal law and his words and actions amount to an advertisement for criminal and unethical conduct"), *appeal denied*, 549 N.W.2d 566 (Mich. 1996), *cert. denied*, 65 U.S.L.W. 3287 (U.S. Oct. 15, 1996) (No. 96-135). Here, the state can legitimately point to the fear of abuse, undue influence and the improper killing of people in situations that are not truly voluntary. This has already happened in the Netherlands, where assisted suicide has been virtually legal for 15 years. Unfortunately, the attempt in the Netherlands to afford "compassion" to the dying has devolved into state-sanctioned non-voluntary euthanasia.

Between 1981 and 1991, the Dutch inexorably moved along a continuum from a heavily regulated regimen of physician-assisted suicide for the informed, competent adult to the non-voluntary euthanasia of infants. "Physician-Assisted Suicide and Euthanasia in the Netherlands," *Report to the Constitution Subcommittee of the House Committee on the Judiciary*, 104th Cong., 2d Sess. (1996) ("Constitution Subcommittee Report").

In 1991 the Dutch Attorney General issued the Remmelink Commission Report (*id.* at 12), finding that in 1990 there were:

> 2,300 cases of voluntary euthanasia;
>
> 400 cases of physician-assisted suicide; and
>
> *more than 1,000 cases of non-voluntary euthanasia.*

In order to justify these non-voluntary euthanasia cases, the Commission explained that

> [T]he ultimate justification for the intervention is in both cases the patient's unbearable suffering. So, medically speaking, there is little difference between these situations and euthanasia, because in both cases patients are involved who suffer terribly.

Constitution Subcommittee Report at 13, quoting Ministerie van justitie, Netherlands, *Outlines Report Commission Inquiry into Medical Practice with Regard to Euthanasia* 3 (1990). The Commission also found that 14 percent of the non-voluntary euthanasia cases were performed on patients who were fully competent and 11 percent of the patients were partially competent. *Id.*

The Commission also found that of the 8,100 cases of morphine overdose in 1990, in 36 percent of the cases the physician's single intent or partial intent was that the morphine kill the patient. *Id.* In over 50 percent of the cases, the physicians administered the morphine overdose without the patient's consent. *Id.* Twenty-seven percent of these non-consenting patients were fully competent. *Id.* The Commission also reported on 25,000 cases of withdrawal of life-sustaining treatment *without* the patient's consent. *Id.*

Our society has known from its earliest times that it was dangerous to allow any ambiguity in the rule against killing. The "rights" recognized by the Ninth Circuit and the Second Circuit are no innocuous grants of personal freedom. *Compassion in Dying* and *Quill* strike at the most fundamental ethical tenets of Western culture. Indeed, they are an invitation to murder. As Cardinal Bernardin states, "[t]here can be no such thing as a 'right to assisted suicide' because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent is self-administered. Creating a new 'right' to assisted suicide will endanger society and send a false signal that a less than 'perfect' life is not worth living." App. A at 2a.

CONCLUSION

The decisions of the United States Courts of Appeals for the Second and the Ninth Circuits should be reversed.

Respectfully submitted.

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NOVEMBER 1996.

APPENDIX A

STATEMENT OF JOSEPH CARDINAL BERNARDIN

The Supreme Court
of the United States
Washington, D.C.

Dear Honorable Justices:

I am at the end of my earthly life. There is much that I have contemplated these last few months of my illness, but as one who is dying I have especially come to appreciate the gift of life. I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention.

In this case, the Court faces one of the most important issues of our times. Physician-assisted suicide is decidedly a public matter. It is not simply a decision made between patient and physician. Because life affects every person, it is of primary public concern.

I have often remarked that I admire the writings of the late Father John Courtney Murray, who argued that an issue was related to public policy if it affected the public order of society. And public order, in turn, encompassed three goods: public peace, the essential protection of human rights, and commonly accepted standards of moral behavior in a community.

Our legal and ethical tradition has held consistently that suicide, assisted suicide, and euthanasia are wrong because they involve a direct attack on innocent human life. And it

is a matter of public policy because it involves a violation of a fundamental human good.

There can be no such thing as a "right to assisted suicide" because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent of death is self-administered. Creating a new "right" to assisted suicide will endanger society and send a false signal that a less than "perfect" life is not worth living.

Physician-assisted suicide also directly affects the physician-patient relationship and, through that, the wider role of physicians in our society. As has been noted by others, it introduces a deep ambiguity into the very definition of medical care, if care comes to involve killing. Beyond the physician, a move to assisted suicide and, perhaps beyond that, to euthanasia creates social ambiguity about the law. In civilized society the law exists to protect life. When it begins to legitimate the taking of life as a policy, one has a right to ask what lies ahead for our life together as a society.

In order to protect patients from abuse, and to protect society from a dangerous erosion in its commitment to preserving human life, I urge the Court not to create any right to assisted suicide.

With cordial good wishes, I am

Sincerely yours,

/s/ Joseph Cardinal Bernardin

Archbishop of Chicago

Chicago, Illinois
November 7, 1996

APPENDIX B

The National Conference of Catholic Bishops has directly dealt with euthanasia and assisted suicide. Directive 60 states:

> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 29 (1995).

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

VACCO *et al., Petitioners*, v. **QUILL** *et al., Respondents*.

On Writ Of Certiorari To The U.S. Court Of Appeals
For The Second Circuit

WASHINGTON *et al., Petitioners*, v. **GLUCKSBERG** *et al., Respondents*.

On Writ Of Certiorari To The U.S. Court Of Appeals
For The Ninth Circuit

BRIEF OF THE NATIONAL CATHOLIC OFFICE FOR PERSONS WITH DISABILITIES AND THE KNIGHTS OF COLUMBUS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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Dated: November 12, 1996

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QUESTION PRESENTED

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Universal Declaration of Human Rights, *reprinted in* Paul Sieghart, *The Lawful Rights of Mankind: An Introduction to the International Legal Code of Human Rights* 172 (1985) . 6

INTERESTS OF THE AMICI CURIAE

The National Catholic Office for Persons with Disabilities (NCPD is a non-profit organization established in 1982 to promote the inclusion of ten million Catholics with disabilities and their families into the mainstream of our society and the Catholic Church. It fulfills its mission through offering its expertise and resources to a national network of disability offices as well as to the U.S. Catholic Conference and other national Church-related organizations. A critical aspect of this nation office's mission is to highlight the value of each life and to encourage the creation of environments which allow each individual to fulfill their potential. If a "right" to assisted suicide for the terminally ill is lodged in the Constitution, then the goals and programs NCPD is pursuing in the interest of persons with disabilities will be for nought. NCPD opposes the legal and social devaluation of persons with disabilities, many of whom have or are regarded as having terminal conditions. Such devaluation will surely result from a constitutional rule transforming their fundamental right to life from an unalienable right to a merely alienable interest based solely on life expectancy.

The Knights of Columbus is an international Catholic fraternal organization of 1.5 million members dedicated to advancing the ideals of charity, unity, fraternity, and patriotism through its activities around the world. The Knights of Columbus engages in a broad range of social action programs to protect the family, and it devotes a considerable portion of its resources and volunteer efforts to aiding persons with illnesses and disabilities, as well as the less fortunate. This brief was written with the support of funds provided by the Knights.

The parties have consented to the filing of this brief. Pursuant to the Rules of this Court, letters of consent from the parties have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

This brief examines the consequences of mandating the selective alienation of the right to live by constitutionalizing an exemption to the homicide code based on the terminal condition of the victim, enabling physicians to assist in suicide by prescribing a lethal drug overdose. Your Amici argue that the decisions in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), and *Quill v. Vacco*, 80 F.3d 716 (1996), involving Fourteenth Amendment challenges to Wash. Rev. Code Ann. § 9A.36.060 (West 1975) and N.Y. Penal Law §§ 120.30 & 125.15 (McKinney 1987), should be reversed.

The rulings below threaten the integrity of our Nation's social covenant, founded as it was on the belief that certain human rights are so fundamental in nature that they cannot be alienated. The Declaration of Independence announced to the world that the American colonists could no longer endure British encroachments on their fundamental and unalienable interests, including especially their right to life. So the doctrine of unalienable rights provided the basis for rebellion and launched a new experiment in American self-governance. Bound up as it is within our legal history and tradition, the governmental duty to respect the unalienable rights of the people serves to this day as a safeguard against tyranny.

The constitutional rule proposed by the courts below would radically transform the right to live from an unalienable right to a merely alienable interest for the most vulnerable persons in society — those having or regarded as having terminal conditions. The rule would permit members of this class to renounce the protections of the homicide code by consenting to another's criminal act of providing suicide assistance, and would force the states to treat the lives of all members of this class as less worthy of protection against homicide. The rule would discount the right to live for all members of this class, regardless of whether they seek to die or desire to live.

At the same time, the rule would endorse the purposeful causing of death, a "right" wholly unique in constitutional law because it encompasses an abuse of liberty. Every other protected freedom is closely related to the constitutional objectives of preserving existence and providing opportunities for social participation. By extending this "right" only to persons with terminal conditions, the courts below would further subject members of this class to social alienation and devaluation.

The lower courts misread the common and statutory law by deriving therefrom a line based on the victim's terminal condition to distinguish the supposed "right" to purposely cause death from the criminal wrong of assisted suicide. Their decisions conflict with the criminal law, which rejects criminal defenses based on the victim's life expectancy and consent. The courts impinged upon the states' exclusive authority to define crimes by mandating such defenses as a constitutional rule. Moreover, the rulings below conflict with this Court's decision in the case of *United States v. Rutherford*, 442 U.S. 544 (1979). *Rutherford* rejected the federal courts' authority to carve a terminal condition exception into otherwise uniform laws designed to protect all persons against dangerous drugs regardless of their life expectancy.

A rule that deems the suicides of persons with terminal conditions to be constitutionally permissible, while leaving the states free to continue their protection of all other persons, inserts into the Constitution an invidious double standard. This Court should reject such a rule and uphold the states' authority to protect the lives of all of its citizens, regardless of condition. The Constitution should not be construed as if it were a suicide pact.

ARGUMENT

I. Our Nation Is Founded On The Principle That Fundamental Human Rights, Particularly The Right To Live, Are Unalienable; A Ruling Granting Constitutional Protection To An Interest In Obtaining Physician-Prescribed Drugs To Purposely Cause Death Would Abandon This Principle.

The Ninth and Second Circuits recognized in *Compassion in Dying* and *Quill* a constitutional right to renounce the protections of the homicide code which deter persons from assisting in the suicides of others with terminal conditions. Properly understood, the alienation of the right to live involves the rejection of otherwise applicable protections against direct threats to one's life. As one commentator explains, "What is given up in the case in which the right to life is waived . . . is not life itself; rather it is the *protection* of life that that right bestows on its possessor." Terrence McConnell, *The Nature and Basis of Inalienable Rights*, 3 Law and Philosophy 25, 37 (1984). Consequently, the constitutional claim before this Court asserts in essence that at least some individuals should be empowered to forgo their right to be protected under the homicide code, thereby alienating their right to live.

If adopted by this Court, then a constitutional rule authorizing some individuals to alienate their right to live based on their life expectancy would undermine principles embraced in the Declaration of Independence. The Declaration put the case for the American rebellion against British rule. The American colonists charged England with "injuries" to and "usurpations" of "certain unalienable rights", including "among these . . . life". Because the King and Parliament assumed a form of government "destructive of these ends", the people had the right to "alter" or "abolish" the old and "institute [a] new government". *The Declaration of Independence* para. 2 (U.S. 1776). In sum, the unalienable rights doctrine provided the essential basis for the American Revolution.

The Declaration's principles have acquired a life of their own, extending their influence far beyond the document's four corners. There is universal agreement that it is,

> the greatest absurdity to suppose it in the power of one or any other number of men at the entering of society, to renounce their essential natural rights, or the means of preserving those rights when the great end of civil government . . . is for the support, protection and defence of those very rights [including] life . . . .

Samuel Adams, *The Rights of the Colonists*, *in* The Founders' Constitution 394, 395 (Philip B. Kurland & Ralph Lerner eds. 1987).

Twenty-nine states have either expressly incorporated the unalienable rights doctrine into their constitutions or adopted constitutional provisions comporting with the doctrine.[1] Furthermore,

> *the Declaration of Independence is . . . funda-*

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[1]The constitutions of twenty three states refer expressly to the "unalienable" or "inalienable" right to life. *See* Ala. Const. Art. I, § 1 (1975); Ark. Const. Art. 2, § 2 (1987); Cal. Const. Art. 1, § 1 (1984); Colo. Const. Art. II, § 3 (1973); Fla. Const. Art. 1, § 2 (1990); Haw. Const. Art. I, § 2 (1993); Idaho Const. Art. I, § 1 (1993); Ill. Const. Art. I, § 1 (1993); Iowa Const. Art. 1, § 1 (1989); Kan. Const. Bill of Rights § 1 (1980); Ky. Const. Bill of Rights § 1 (1988); Me. Const. Art. I, § 1 (1985); Mass. Const. Pt. 1, Art. I, (1978); Mont. Const. Art. II, § 3 (1995); Neb. Const. Art. I, § 1 (1995); Nev. Const. Art. 1, § 1 (1995); N.J. Const. Art. 1, para. 1 (1971); N.M. Const. Art. II, § 4 (1992); N.C. Const. Art. I, § 1 (1995); N.D. Const. Art. I, § 1 (1981); Ohio Const. Art. I, § 1 (1994); Utah Const. Art. I, § 1 (1991); Vt. Const. Chap. I Art. 1 (1996). Three other state constitutions refer either to a right to life that is "indefeasible" (Pa. Const. Art. I, § 1 (1994), or one that cannot be "divest[ed]". Va. Const. Art. I, § 1 (1995) & W. Va. Const. Art. III, § 1 (1983). New Hampshire's constitution refers to the right to life as "natural", "essential" and "inherent". N.H. Const. Pt. 1, Art. 2 (1988). Two other state constitutions contain provisions that comport with the unalienable rights doctrine. La. Const. Art. 1, § 1 (1996) (prohibiting euthanasia) & Miss. Const. Art. 3, § 19 (1974) (prohibiting duelling).

> *mental to a proper understanding of the [federal] Constitution;* and . . . abundant support for this proposition can be found in the leading writings and debates of the Founding era. Indeed, it would hardly be an exaggeration to say that the most fundamental pronouncements made in connection with the framing and ratification of the Constitution are restatements of the principles articulated in the [Declaration] . . . .

Dan Himmelfarb, Note, *The Constitutional Relevance of the Second Sentence of the Declaration of Independence*, 100 Yale L. J. 169, 170-71 (1990) (emphasis added); *see also Monangahela Navigation Co. v. United States*, 148 U.S. 312, 324 (1893) (noting that the Bill of Rights was adopted to protect "those rights of persons and property which by the Declaration of Independence were affirmed to be unalienable rights"); *Gulf, Colorado & Santa Fe Railway v. Ellis*, 165 U.S. 150, 159-60 (1897); *McGowan v. Maryland*, 366 U.S. 420, 563 (1961) (Douglas, J., dissenting) ("[T]he body of the Constitution as well as the Bill of Rights enshrined those principles [of the Declaration].").

The Fourteenth Amendment was drafted with the Declaration very much in mind. *See* Hermine H. Meyer, *The History and Meaning of the Fourteenth Amendment* 75 (1977) (referring to remarks during congressional debates on the Amendment by a sponsor, Representative Thaddeus Stevens, who observed that "I can hardly believe that any person can be found who will not admit that every one of these provisions is just. They are all asserted, in some form or other, in our DECLARATION or organic law.") (capitalization in original).

Finally, the unalienable rights doctrine serves as an international measure of humane and just governments. *See* Preamble to the Universal Declaration of Human Rights, *reprinted in* Paul Sieghart, *The Lawful Rights of Mankind: An Introduction to the International Legal Code of Human Rights* 172 (1985) (asserting that "recognition of the inherent dignity and

of the equal and inalienable rights of the all members of the human family is the foundation of freedom, justice and peace in the world"); *id.* at 42 (observing that while international human rights law recognizes that some rights can be acquired or renounced through personal transactions, "none of this applies to 'human' rights. . . . [T]he code [of international human rights laws] simply treats us as coming into the world with them. . . . nor can we sell them, mortgage them, or forfeit them").

Assisted suicide and voluntary active euthanasia "can both be viewed as efforts to alienate the inalienable, to give away what cannot properly cannot be given away." Joel Feinberg, *Voluntary Euthanasia and the Inalienable Right to Life*, 7 Philosophy & Public Affairs 93, 93 (1978). In accord with this principle, the states have prohibited the aiding and abetting of suicide, along with other forms of consensual homicide and self-harm. *See, e.g., Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1972) (referring to laws against such consensual activities as "bare fist" prize fights and duelling); *Martin v. Commonwealth*, 184 Va. 1009, 37 S.E.2d 43, 47 (1946) (consent is no excuse for homicide because the right to life is unalienable); *State v. Moore*, 25 Iowa 128, 135-36 (1868) (recognizing that the "right to life and to personal safety is not only sacred in the estimation of the common law, but it is inalienable").

Accordingly, this Court should not abandon a core doctrine upon which this Nation was founded, but instead should affirm laws that, by uniformly forbidding suicide assistance, preserve the unalienability of the right to live and thereby respect the equal dignity of all persons. Such laws reflect our founding principles, and they are just as vital to our society today as they were 200 years ago.

As one commentator explained,

> [the Declaration] linked the unalienable rights of individuals with the people's right to rebel. In the background there is the basic idea that a

> social contract of some sort had been made in which the people transferred certain rights to government in return for something. . . . What rights the people transferred is less important than the rights they did *not* transfer because they were not transferable, that is to say, unalienable. Unalienable rights were thought to be held under *any* form of government so that when a government merely showed signs of wishing to invade these rights, it could be regarded as intending to reduce the people under absolute despotism.

Morton White, *The Philosophy of the American Revolution* 239-40 (1978).

In view of the nexus between unalienable rights and the limits on despotic governance, a constitutional policy endorsing the selective alienation of the right to live raises profound questions. As one commentator has observed, "[W]e must recall that [John Locke] puts the inalienability of the right to life to good purposes when he uses it to explain why a government can never legitimately acquire an absolute rule to dispose of the lives of its citizens." Lance K. Stell, *Dueling and the Right to Life*, 90 Ethics 7, 16 (1979). Thus, the right to live is a fundamental human interest "that no man *should* transfer to any person or any government." White, *American Revolution* at 220.

What damage will be inflicted on the inviolability of life by a constitutional rule rejecting its unalienability? Will governments be free to acquire absolute dominion over persons whose fundamental rights are deemed personally transferable and thus disposable? Will society become even more coursened in its disregard for the sanctity of human life? These questions cannot be ignored because constitutional rules cannot be imposed in a vacuum.

Moreover, a rule supposedly grounded in notions of autonomy and individual freedom will unjustifiably alter the

legal status of those who have no desire to kill themselves, but who nevertheless will be swept into the category of persons deemed to have an alienable right to live. The right to live and all rights flowing therefrom will be rendered alienable not because an individual so chooses, but on account of the individual's condition. If some persons with terminal conditions are permitted to alienate their right to live because they are terminally ill, then all persons with terminal conditions will necessarily be free to make the same choice. As a consequence, by virtue of constitutional mandate and irrespective of individual desires, the right to live for all members of this class will be reduced to an inferior, alienable status. Because every member of the affected class will no longer possess an unalienable right to live, each will be left with a weaker claim, or no claim at all, against tyrannical notions of "normalcy" and "quality of life" policy-making.[2]

Finally, a constitutional rule that permits some — but not all — persons to alienate their right to live cannot be squared with the Declaration's finding and the Fourteenth Amendment's proviso that *all* persons are created equal and as a result are equally endowed with unalienable rights. Once it is posited that some persons have only an alienable right to live, then an inequality of human dignity profoundly hostile to our Nation's founding principles not only will threaten the fundamental interests of the vulnerable, but also

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[2]One commentator has remarked on

> just how dangerous enforced physiological normality is when the definition of its parameters falls into the hands of politicians and bureaucrats. . . . [T]he war against "abnormality" implies a dangerous kind of politics, which begins with a fear of difference and eventuates in a tyranny of the normal. That tyranny, moreover, is sustained by creating in those outside the norm shame and self-hatred — particularly if they happen to suffer from that vast majority of "deformities" which we still cannot prevent or cure.

Leslie A. Fiedler, *The Tyranny of the Normal*, Hastings Center Report, Apr. 1984, at 40, 41, 42.

will imperil the integrity of our constitutional order.

II. A Constitutional Rule Permitting Persons To Alienate Their Right To Live Because They Have, Or Are Regarded As Having, A Terminal Condition Lacks A Legitimate, Non-Invidious Basis.

The Ninth and Second Circuits ruled that at least in some cases suicide assistance is constitutionally protected, and that a line must be drawn between the criminal wrong and the constitutional right based on the victim's life expectancy. The "courts may not", however, "draw lines which appear arbitrary without . . . offering a justification." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 870 (1992). The line chosen by the lower courts not only *is* arbitrary, but also is based on the invidious assumption that the lives of persons with terminal conditions are less worthy or deserving of protection.[3]

The Ninth and Second Circuits claimed that the common law and state statutes governing treatment refusals provided the basis for recognizing in the assisted suicide context a diminishing state interest in "preserving" the lives of persons with terminal conditions. The courts misread the law, however, and confused an interest in "preserving" life with the states' separate interest in "protecting" life.

The "terminal condition" line cannot be adduced from an accurate reading of the common law of informed consent, which extends the right to refuse treatment to all persons regardless of life expectancy. 1 Alan Meisel, *The Right to Die* 490-91 (2d ed. 1995) (referring to case law extending the right to refuse treatment to persons who are not terminally

[3]*See City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985) (observing that certain classifications "are so seldom relevant to the achievement of any legitimate state interest that laws grounded in such considerations are deemed to reflect prejudice and apathy — a view that those in the burdened class are not as worthy or deserving as others").

ill). Advance directive statutes often limit their scope to cases involving incompetent persons who are terminally ill, but they must be read together with the broader common law rule. Rather than limiting treatment refusals, these statutes establish a legal "safe harbor" for advance directive decision making. *See* 2 Meisel, *The Right to Die* at 85 (noting that most advance directive statutes expressly decline to supersede the common law or to set out the sole means by which the right to refuse treatment may be exercised; also noting that a majority of courts has therefore concluded that such legislation does not preempt or otherwise narrow the common law).

Moreover, whether a person has a terminal condition is relevant to the treatment refusal context only for reasons quite irrelevant to the assisted suicide context. When weighing the benefits and burdens of accepting medical treatment, a patient must necessarily consider the treatment's capacity to extend life. If a patient is terminally ill, so that the treatment will not extend his or her life indefinitely, then the state's interest in preserving life will not be implicated. *See In re Grant*, 109 Wash. 2d 545, 556, 747 P.2d 445, 451 (1987) (observing that state interest in "preserving life" by requiring "lifesaving" treatment "weakens considerably . . . if treatment will merely postpone death for a person with a terminal and incurable condition"). The state's interest in preserving life is measured according to the effectiveness of treatment in question, and does not depend on any value assessment of the lives at stake. *See also Fosmire v. Nicoleau*, 551 N.Y.S. 2d 876, 881, 551 N.E.2d 77, 82-83 (1990) (holding that patients' terminal condition is relevant only "to determine whether [this is] the circumstance[] in which the patients intended to decline the medical care" and not "because the State considered their lives worthless").

In the assisted suicide context, however, the issue is not whether the state has an interest in *preserving* life by providing treatment, but whether the state may seek to *protect* all lives against direct killing. Persons with terminal conditions are still alive, whether or not their lives can be indefinitely extended by life supports. Thus, even when it is impossible

to effectuate the state's interest in preserving their lives because life-sustaining measures are unavailing, the separate issue remains as to whether the state's interest in protecting life against killing should apply.

Consequently, the lower courts engaged in pretextual reasoning by referring to the common law of consent and the statutory law governing advance directives as bases for drawing a line at terminal condition. *See Compassion in Dying*, 79 F.3d at 817-20 and *Quill*, 80 F.3d at 727-28; *but see* 79 F.3d at 819 (quoting preamble to Washington's advance directive statute expressing the legislature's finding that without qualification "adult persons" have the right to control medical decisions, and importantly, that this right is not limited to but "*includ[es]*" those decisions involving "instances of terminal condition", thereby extending the right to refuse treatment both to persons who are and who are not terminally ill) (emphasis added) & *Fosmire*, 551 N.Y.S.2d at 881, 551 N.E.2d at 82 (finding that common law right to refuse treatment in New York extends to all competent adults regardless of condition).

As the next two sections will demonstrate, neither the criminal law nor the constitutional rulings of this Court provide an alternate basis for mandating an exemption from the homicide code based on the victim's life expectancy. To the contrary, our legal history and tradition, as well as this Court, have rejected the victim's condition as constitutionally irrelevant.

A. *Considerations Under The Criminal Law: The Definition Of Homicide And The "Last Spark Of Life".*

Criminal jurisprudence provides an instructive approach to resolving whether a non-invidious foundation exists for using a suicide victim's terminal condition as a constitutional dividing line. Many of the arguments favoring a limited right to assisted suicide for persons with terminal conditions resemble the defenses that might be raised in a trial for homicide. Thus, the definitional elements of causation, intent,

excuse, and justification provide a useful framework for addressing — and ultimately rejecting — any claim that a suicide victim's life expectancy is at all constitutionally relevant.

For example, the Ninth Circuit raised an argument sounding in causation by contending that a decision to hasten death should not be classified as suicide when the victim's "death is already in process". *Compassion in Dying*, 79 F.3d at 824. *But see People v. Moan*, 4 P. 545 (Cal. 1884) ("If a patient is lying in the last stages of consumption, with a tenure upon life that cannot possibly continue for a day, it is homicide to administer a poison to him by which his life is ended almost immediately.")

In addition, an amicus brief filed with the Ninth Circuit asserted that in cases involving suicidal persons with terminal conditions, the participants necessarily lacked the requisite criminal intent. Instead, the suicide assistant "seeks to end the [victim's] dying process", and the victim "does not have the primary goal of ending his life", because "[g]iven the terminal nature of his condition, the [victim] wants to end his suffering by shortening the dying process." Amicus Curiae Brief of the Americans for Death With Dignity and Euthanasia Research & Guidance Organization at 4 n.6, *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 94-35534). *But see Gilbert v. State*, 487 So. 2d 1185, 1191 (Fla. App. 1986) (rejecting defense to homicide based on claim that defendant sought only to end the victim's suffering because it would "sanction open season" for the killing of vulnerable persons).

Moreover, assisted suicide is defensible in The Netherlands on the excuse-related ground that a physician charged with a crime should not be convicted if he or she participated in a suicide under emotional duress, and was compelled to end another's misery when confronted with the victim's condition. Herbert Hendin, *Seduced by Death* 94, 103, 109 (1997). *But see State v. Fuller*, 203 Neb. 233, 243, 278 N.W.2d 756, 762 (1979) ("Duress or compulsion is no excuse to the charge of homicide.").

Finally, the respondents in *Glucksberg* raise a justification-related defense by asserting that any conflict between the state's interest in protecting life and an individual's interest in death must tilt in favor of death when the life at stake is of a "limited *quantity*". Opposition to Petition for Writ of Certiorari at 12, *Washington v. Glucksberg* (No. 96-110). ***But see*** *State v. O'Brien*, 46 N.W. 752, 753 (Iowa) ("The fact that [the homicide victim] was afflicted with a disease which might have proved fatal would not justify the wrongful acts of defendant . . . .").

The Ninth and Second Circuits would impose these theories on the states as constitutional mandates, contrary to this Court's long line of precedents leaving to the states the authority to define crimes, particularly in reference to the "doctrines of *actus reus, mens rea,* insanity, mistake, justification and duress". *Montana v. Egelhoff*, 64 U.S.L.W. 4500, 4505 (U.S. June 13, 1996) (No. 95-566). Moreover, such mandates would conflict with our legal history and tradition, which unanimously reject any defenses to homicide based on the victim's health status.

One court described the rule of law as follows:

> But though a human body must be alive in order that it may be the subject of homicide, yet the quantity of vitality which it retains at the moment the fatal blow is given, and the length of time life would otherwise have continued, are immaterial considerations. If any life at all is left in the human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being.

State v. Francis, 149 S.E. 348, 364 (S.C. 1929). *Accord State v. Mally*, 366 P.2d 868, 873-74 (Mont. 1961); *People v. Stamp*, 82 Cal. Rptr. 598, 603 (Cal. App.), *cert. denied*, 400 U.S. 819 (1970); *see* Daniel Avila, *Is the Constitution a Suicide Pact?*, 35 Duquesne Law Review 201, 227-230 (1996) (discussing these and other cases).

In light of this rule and its broad acceptance in our law, any attempted justification for abandoning to their suicidal impulses only persons with terminal conditions, and exposing only them to the undeterred efforts of others to assist in their deaths, bolsters the inference that an invidious disregard for the lives of the vulnerable is at play. If "[a]n accused cannot speculate as to how long his victim may live with an incurable malady when he inflicts a shot or a wound that hastens the death or the action of the fatal disease" (*State v. O'Brien*, 46 N.W. 752, 753 (Iowa 1890)), then neither should the Constitution.

If this Court were to adopt the contrary position and hold as a matter of constitutional law that the victim's proximity to death is relevant to the culpability of an individual charged with assisting suicide, then the definitional ramifications would be far-reaching. Assisted suicide cannot be distinguished from other forms of homicide. If the victim's condition is deemed relevant in the assisted suicide context, then it must also be relevant in any case of homicide. As a result, virtually any defendant accused of a homicidal act would have the constitutional right to raise the victim's debilitated condition as a defense.

By definition then, crimes against life would be limited only to those life-threatening acts which imperil the healthy and long-living. Those charged with mortally attacking an individual deemed to be in an accelerated "process of dying" could avoid conviction. Because "process of dying" is an inherently expansive concept — all persons are going to die sometime and many are going to die sooner than expected for a variety of reasons — an assortment of defense claims based on the victim's condition would emerge in a host of cases.[4]

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[4]Such a rule would also open the door to constitutional defenses based on the victim's consent, thereby overriding state policies rejecting such defenses in cases involving homicide and other crimes. *See, e.g., State v. Fuller*, 203 Neb. at 241, 278 N.W.2d at 761 (holding that "murder is no less murder because the homicide is committed at the desire of the victim"); *Jones v. State*,

B. *Considerations Under The Constitution: Fourteenth Amendment Exemptions And United States v. Rutherford.*

This Court's unanimous decision in *United States v. Rutherford*, 442 U.S. 544 (1979), rejected a similar exemption based on a person's terminal condition. The Court ruled that a uniform federal ban against the interstate transfer of unsafe or unproven drugs reasonably applied to an experimental and potentially harmful substance (laetrile) sought by persons with terminal cancer as a last ditch means of extending their lives. *Id.* at 559. The Court found that "[f]or the terminally ill, as anyone else, a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit." *Id.* at 556. Moreover, "it is often impossible to identify a patient as terminally ill except in retrospect." *Id.* at 556. Finally, the Court was unwilling to endorse the proposition "that . . . safety and efficacy standards . . . have no relevance for terminal patients" because this would "deny the [government's] authority over all drugs, however toxic or ineffectual, for such individuals." *Id.* at 557-58. Thus, the Court refused to read an implied exception into an otherwise generally applicable statute since "federal courts do not sit as councils of revision, empowered to rewrite legislation in accord with their own conceptions of prudent public policy." *Id.* at 555.

Rutherford should pose a significant obstacle to any constitutional claim for assisted suicide based on a victim's proximity to death. If Congress may restrict the use of dangerous drugs by persons with terminal conditions seeking to prolong their lives, then surely the states may deter physicians from supplying lethal dosages to members of the same class who want to end their lives. The parallels between the two cases simply cannot be ignored.

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640 So. 2d 1084 (Fla. 1994) (rejecting claim of a right to such a defense under the state constitution in a case involving charges brought under statutory rape law, even though the victim "did not want the 'protections' advanced by the state").

Thus, in light of *Rutherford*, laws discouraging drug-induced deaths among the terminally ill, as for anyone else, reasonably furthers the states' general goal of protecting life. The constitutional balance between state interests and competing private interests should not be shifted according to the victim's life expectancy. In sum, the terminally ill are similarly situated with everyone else in relation to the states' interest in protecting life. For the Court to hold otherwise, it would have to abandon *Rutherford* and entirely reverse its course with respect to constitutional exemptions generally.

III. A Constitutionally-Mandated Policy Permitting The Selective Alienation Of The Right To Live Based On A Suicide Victim's Life Expectancy Threatens The Welfare And Safety Of Vulnerable Persons And Imperils Ordered Liberty.

To deflect concerns about assisted suicide raised by persons with disabilities and members of other vulnerable populations, the Ninth and Second Circuits responded with assurances that suicide is a constitutional benefit. *Compassion in Dying*, 79 F.3d at 825-26; *Quill*, 80 F.3d at 730. Based on the considerations addressed in the remainder of this brief, your Amici disagree strongly.

A. *Unlike Any Other Constitutional Freedom, A "Right" To Alienate One's Right To Live Licenses The Intentional Destruction Of Persons' Lives.*

In no other case has the Supreme Court been asked to license an individual to assist in the intentional destruction of life at the request of the victim. All other claims of personal freedom granted constitutional protection have related in some meaningful way to the individual's enjoyment of life and continued participation in society. Thus, the Supreme Court has "reject[ed] at the outset the notion that *any* grievous loss visited upon a person by the State is sufficient to invoke" a constitutional remedy. *Meachum v. Fano*, 427 U.S.

215, 224 (1976). Whether an asserted interest to act free from government interference rises to the level of a constitutional right will depend on its "nature" — that is, its relation to the "'whole domain of social and economic fact'" (*Morrissey v. Brewer*, 408 U.S. 471, 481 (1972) (citation omitted)), as well as on its connection to an individual's ability to "'engage in any of the common occupations of life'". *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 572 (1972) (citation omitted).

Conversely, a "right" or "liberty" to obtain suicide assistance would lack any relation to the capacity to exist, move freely, and form personal attachments in society; it would be entirely antithetical to such exercises of liberty. *See Morrissey*, 408 U.S. at 482 (holding parole to be cognizable Fourteenth Amendment liberty because it "enables [offenders] to do a wide range of things open to persons who have never been convicted of any crime" such as "to return to society", "be gainfully employed", be "free to be with family and friends and to form the other enduring attachments to normal life"). Assisted suicide accomplishes the purposeful destruction of life and, as a result, forever cuts the victim off from all ties to family, friends, and society. It thus fails to achieve any "benefit" of existence or social inclusion ascertainable under the Constitution.

The Ninth and Second Circuits attempted to graft assisted suicide to the outer branches of the right to accept or refuse medical treatment. *Compassion in Dying*, 79 F.3d at 822-23 (discussing acceptance of morphine drips and refusal of tube-feeding); *Quill*, 80 F.3d at 729 (same). They argued that if the Constitution recognizes a right to make medical decisions, then it should recognize the right to assisted suicide. The courts thus contended that the personal and state interests at stake in treatment refusal and assisted suicide cases are indistinguishable, particularly with respect to their relationship to death.

On the contrary, the right to accept or refuse treatment differs significantly from an interest in suicide assistance

precisely because treatment decisions can enable persons to "engage in the common occupations of life". Moreover, the constitutional strength of an interest in making treatment decisions diminishes as the risk of death increases, while the proposed interest in assisted suicide would increase in strength *because* its objective is death.

This Court has acknowledged the existence of a "right to decide independently, with the advice of [a] physician, to acquire and to use *needed* medication [i.e., essential to health]." *Whalen v. Roe*, 429 U.S. 589, 603 (1977) (emphasis added). Treatment may be necessary to prolong life, to alleviate pain, or to overcome any other maladies which might hinder an individual's capacity to work or to engage in social activities. These benefits undoubtedly comport with the Constitution's life-enhancing objectives.

In addition, this Court has recognized an interest "in avoiding the unwanted administration of . . . drugs". *Washington v. Harper*, 494 U.S. 210, 221-22 (1990). This interest also relates to constitutional objectives by directly implicating the freedom to move about in society unimpeded by the intrusive restraint of a technological apparatus or the forced ingestion of pills or medication. *See Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 269, 278, 279 (1990) (referring to an interest in avoiding unwanted bodily intrusions).

To the extent that a decision to accept or refuse treatment implicates hastened death, this Court has permitted the states to limit the decision maker's discretion. Thus, the states may "prohibit entirely the use of particular drugs" deemed dangerous to the patient's health and safety (*Whalen*, 429 U.S. at 603), and may consider such "dramatic consequences" as death when weighing the policy implications of refusing treatment. *Cruzan*, 497 U.S. at 279. Far from endorsing in these cases any principle that would support the creation of a right to purposely cause death, the Court has permitted the states to circumscribe the right to accept or refuse treatment in direct proportion to the likelihood that

death will result.

Fundamental rights are protected because they enable individuals to live freely and interact socially, even if at times their exercise involves personal risk.[5] The rights to speak, vote, travel, refuse treatment, and so on, could be equated to assisted suicide only by irrebuttably imputing to the citizen who chooses to exercise them in risky situations an inherent desire to be harmed — and by falsely imputing to the Constitution's framers the intent to recognize death as simply another noble objective.

Instead, a constitutionally protected decision to purposely seek death would be unique among all other protected choices. It would embrace a lethal purpose, while the exercise of other rights merely tolerate certain residual and unavoidable risks. Its objective is death rather than life, and its exercise results in irreversible alienation rather than social participation. While the "recognition of any right creates the possibility of abuse" (*Compassion in Dying*, 79 F.3d at 831), a constitutional policy favoring assisted suicide eliminates any contingency by endorsing what is itself a form of abuse. Indeed, the abuses of other freedoms — involving threats against life and self-expulsion from society — would frame the essence of this new right. The dangers its constitutional enshrinement would pose for persons with terminal conditions, other vulnerable populations, and society itself would be of a far greater magnitude than the risks created by the exercise of any other right.

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[5]The Supreme Court has noted that "[s]ome cost will be paid by anyone who approves or implements a constitutional decision where it is unpopular, or who refuses to work to undermine the decision or to force its reversal. The price may be criticism or ostracism, or it may be violence." *Casey*, 505 U.S. at 867.

B. *A Constitutional Rule Establishing The Freedom To Renounce Society's Protection Of One's Right To Live Would Ratify The Most Extreme Form Of Social And Political Alienation.*

While the assisted suicide claim before this Court ostensibly concerns individual rights, the Court must also consider the social consequences. In particular, constitutionalizing the right to seek to harm one's self with the assistance of others says just as much about the constitutional status of persons granted this right as it says about the right itself. Thus, the question is broader than "does the life-destroying right to assisted suicide share equal billing with other freedoms that are instead life-enhancing?" The inquiry must also focus on why the right to live of some persons should be slashed in value from an unalienable to an alienable constitutional interest.

The Ninth and Second Circuits tied the strength of one's right to live to one's proximity to death, thereby provoking a profound fear among many of those persons in society whose disabilities leave them with an already precarious hold on life. Every person with a disabling condition is already more intensely aware than most of life's contingent nature, even if his or her present condition is not certifiably terminal. Many persons with disabilities were disabled by accidents and thus have peered through the gates of death before medicine made survival possible. Many persons with disabilities rely on high tech interventions to survive, to breathe or to eat, and they are constantly reminded by the nature of their ongoing care that without proper treatment or care they would soon die. Many persons with disabilities depend on the assistance of family, friends, and professional caregivers and must orchestrate ever-shifting schedules simply to meet the minimum requirements of daily living. Some, like the actor Christopher Reeves, cannot function without substantial medical and personal assistance. Most are far less capable than a wealthy movie star of meeting the financial burdens of their care, however, and few enjoy the same public esteem.

Most members of this class are unquestionably more vulnerable to discrimination and social alienation.

Many persons with disabilities exist in a state of "virtual terminality" because the frailty of their physical condition and the specter of death are so intimately woven together. In turn, a constitutional decision asserting that their right to live is constitutionally disposable makes them "virtual aliens" because their most fundamental right — the protection of life — would hang only by the single thread of their own resolve to keep it. They will be left far less secure against both internal and external pressures to give away this right to the unjust advantage of others.

In the end, a condition-based rule in favor of assisted suicide would pour into the Constitution a poisonous concoction of warm-hearted, misguided pity and cold-hearted utilitarianism. The question of "whether we as a society are willing to excuse the terminally ill for deciding that their lives are no longer worth living" would be mixed inextricably with the question of whether assisted suicide should serve as a means "for housecleaning, cost-cutting and burden shifting — a way to get rid of those whose lives we deem worthless." *Compassion in Dying*, 79 F.3d at 856-57 (Beezer, J., dissenting). Who stands to benefit most from a constitutional policy by which the right to live of vulnerable persons is reduced to an alienable interest? Is it the person with a terminal condition bent on suicide regardless of what the Constitution holds, or is it a cost-conscious society seeking more ways to ration its generosity?

C. *A Constitutional Rule Limiting Assisted Suicide To Persons With Terminal Conditions Offers A False And Dangerous Compromise.*

Proponents of assisted suicide strive to appear moderate and attempt to strike a balance between what they perceive to be extremes on both ends of the spectrum. They claim that, while an across-the-board ban is too restrictive for their

tastes, unrestricted suicide is not their aim. They would agree to the construction of what is, in effect, a brick wall across the slippery slope — supposedly to accommodate both the "hard cases" and society's general abhorrence of intentional killing. The Ninth and Second Circuits extended this call for compromise in the constitutional order by overriding the states' uniform bans against assisted suicide, yet nevertheless recommending the adoption of various legislative safeguards. *Compassion in Dying*, 79 F.3d at 832-33; *Quill*, 80 F.3d at 730.

Such appeals for compromise seek to divide permissible from impermissible suicides according to the victim's proximity to death and quality of life. They assume that the desirability of death can and should be balanced against the desirability of life by referring to a person's physical and mental condition. No matter how desperate for death suicidal individuals may be and no matter how little they may value their own lives, their requests to die will be approved only according to a social, not individual, estimation of the comparative values of their life and death. Through such a calculus, the law and the community would sanction death not because the victim wants it, but because the victim who wants it also happens to have a condition that the law and community identify as unworthy of protection.

Moreover, such a policy would still permit the states to punish suicide assistance when the victim is not terminally ill. The retention of a uniform ban evinces the belief that suicide is a bad thing both for the victim and society, and that the law's protection is a benefit — yet *only* if the victim is healthy and expected to live indefinitely. Because the resulting disparity in the level of protection would create an apartheid based on one's health status, the lower courts' assertion that suicide is a constitutional benefit should be rejected on its face.

Why is it beneficial for persons with terminal conditions but no one else to obtain lethal medications to kill themselves? The question calls for a more compelling response

because one can easily infer from the circumstances an invidious motive.[6] A policy which permits lethal assistance for some, but not for the majority, implicates the view that those provided the lethal assistance are less worthy or deserving of protection, and that their lives have less value under the law. Such a policy would fundamentally alter our country's commitment to providing equal protection to vulnerable persons.

As one commentator has written:

> [Our society's] liberal commitment to limited popular government requires a commitment to the equal worth of each person and to limits on the power of government that are contained in the teaching of inalienable rights, especially an inalienable right to life. This teaching forms the essential horizon of liberal theory and it is only within this horizon that liberal regimes and the policies they endorse can take shape. . . . Given the liberal commitment to equality as the precondition of liberty, the "new consensus" [proposing that certain suicides be sanctioned based on the assumption that some lives are less valuable than others] fails completely in its policy recommendations. The policies these writers wish to see adopted logically entail the creation

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[6]A Florida statute making consensual sexual activity with "chaste" minors a crime but not with "unchaste" minors created a similar invidious inference, according to an opinion found in *B.B. v. State*, 659 So. 2d 256 (Fla. 1995). Florida Supreme Court Justice Kogan asserted that such a law

> seems to regard unchaste minors as being somehow less deserving of the state's protection than those who are [chaste]. . . . Any statute that purports to grant special status to a favored group . . . over all others, to my mind at least, must be regarded as inherently questionable. On its face this statute suggests discrimination. . . . Laws should protect everyone, not merely a favored group.

Id. at 260-61 (Kogan, J., concurring).

> of a public standard for determining when some lives are in fact not worth living anymore. However, this is a judgment that is fundamentally inconsistent with the premises of the very regime that is supposed to adopt this policy.

Richard Sherlock, *Suicide and Public Policy: A Critique of the "New Consensus"*, 4 Journal of Bioethics 58, 62 (1982-83).

For this reason, the law should not abandon whole categories of the most vulnerable individuals under the guise of protecting individual rights. Instead, as concluded by the British Medical Association,

> the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. It is instead, an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.

British Medical Association, *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* 69 (1988).

This Court has assured the Nation that "while the Constitution protects against invasions of individual rights, it is not a suicide pact." *Haig v. Agee*, 453 U.S. 280, 309 (1981) (quoting *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 160 (1963)). Consistent with this assurance, this Court should reject the Ninth and Second Circuit rulings.

CONCLUSION

For the foregoing reasons, the judgments of the Ninth and Second Circuits should be reversed.

ing *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 160 (1963)). Consistent with this assurance, this Court should reject the Ninth and Second Circuit rulings.

CONCLUSION

For the foregoing reasons, the judgments of the Ninth and Second Circuits should be reversed.

Respectfully submitted,

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Nos. 95-1858 and 96-110

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF *AMICUS CURIAE* ON BEHALF OF MEMBERS OF THE NEW YORK AND WASHINGTON STATE LEGISLATURES IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICI

Amici curiae are New York and Washington state legislators who strongly support the public policy expressed in their state laws prohibiting assisted suicide and who vigorously oppose efforts to legalize assisted suicide in the legislatures or the courts. *Amici* firmly believe that there is no social, economic or medical need to permit physician-assisted suicide under any circumstances, and that to allow suicide assistance, even for mentally competent, terminally ill adults, would lead to grave abuses and exploitation of the most vulnerable members of our community, as it already has in the Netherlands. *Amici* fully concur with the warning of the New York State Task Force on Life and the Law that creation of a right to suicide "would carry us into new terrain."

> American society has never sanctioned suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.
>
> WHEN DEATH IS SOUGHT[:] ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT vii-viii (May 1994).

This Court should heed their warning and not recognize a right to suicide or suicide assistance.*

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* This Brief is filed with the consent of the parties. Letters of consent have been lodged with the Clerk of the Court.

SUMMARY OF ARGUMENT

In a pair of unprecedented opinions, the Second Circuit and the Ninth Circuit have held that New York and Washington are powerless to prevent mentally competent, terminally ill patients from intentionally ending their lives with the assistance of physicians who are willing to prescribe lethal drugs for them. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996). In recognizing a right to commit suicide with the assistance of third parties, the *en banc* majority in *Compassion in Dying* swept aside a uniform tradition of legal and societal opposition to suicide and assisted suicide that dates back to the earliest days of the common law. Contrary to the Ninth Circuit's opinion, nothing in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), required or allowed the court of appeals to ignore this history in evaluating plaintiffs' wholly novel constitutional claim.

Compounding this error, both the Ninth Circuit and the Second Circuit seriously misread this Court's decision in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). Both courts attempted to derive an interest in deliberately inducing death, which the law always has treated as a crime, from the interest in refusing unwanted medical treatment, which the law traditionally has protected out of respect for the inviolability of the human person. Disregarding critical distinctions between *intending* a result and *knowing* that a result is likely, and between *causing* death artificially and *allowing* death to occur naturally, the lower courts reasoned that because refusing life-sustaining treatment and intentionally ingesting a fatal dose of drugs both result in a person's death, the right to do the former necessarily entails the right to do the latter. *Quill*, 80 F.3d at 725-31; *Compassion in Dying*, 79 F.3d at 820-24. "But constitutional law does not work that way." *Cruzan*, 497 U.S. at 286.

At the outset, *amici* note that this Court has never held that "a competent person has a constitutionally protected liberty interest" in refusing "life-sustaining medical treatment." *Cruzan*, 497 U.S. at 278, 279. In *Cruzan*, the Court *assumed*, for purposes of deciding the case, that the Constitution "would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. Nevertheless, the Court cautioned that "the dramatic consequences involved in the refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible," *id.*, thereby implying that the State's "interest in the protection and preservation of human life," *id.* at 280, might be sufficient to outweigh the patient's interest in refusing unwanted treatment. That implication was made explicit when the Court said, "We do not think that a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Id.*

Even if it is assumed that a competent person has a constitutionally protected liberty interest in refusing life-sustaining treatment, that interest has its origins in the law of battery and the doctrine of informed consent (*see Cruzan*, 497 U.S. at 269-77) which both define its nature and limit its scope. The interest restricts "governmental power to mandate medical treatment or bar its rejection," *Casey*, 505 U.S. at 857, but does not confer a right to insist upon a particular form of treatment, much less one that will cause, and is intended to cause, the person's death. *See United States v. Rutherford*, 442 U.S. 544 (1979) (FDA had authority to proscribe laetrile, even for terminally ill cancer patients). It is the source and the nature of the interest that determine its ultimate reach. Whether the constitutionally protected interest in refusing unwanted medical treatment extends to life-sustaining treatment, a question this Court need not answer here, that interest clearly has reached its furthest

limit when all treatment—life-sustaining or otherwise—has been withheld or withdrawn.

Beyond their multiple errors in analysis, however, the decisions in both *Compassion in Dying* and *Quill* are, in principle, illimitable. If the right to refuse unwanted medical treatment is the doctrinal source of a right to assistance in committing suicide, it is apparent that the latter right cannot be confined to mentally competent, terminally ill patients, as the Ninth Circuit admitted. *See* 79 F.3d at 816, 831-32 & n.120. The lower court decisions, if affirmed, would plunge the country into a generation of constitutional conflict over the nature and extent of the "right," a conflict which would cause irreparable damage to the Nation, to the American People and to this Court. *Amici* ask the Court not to take this precipitous step.

ARGUMENT

I. THE LIBERTY LANGUAGE OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS ONLY THAT CONDUCT WHICH IS IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY AND WHICH, HISTORICALLY AND TRADITIONALLY, IS CONSIDERED BEYOND THE POWER OF THE STATE TO PROHIBIT.

The Ninth Circuit held that there is "a constitutionally-protected liberty interest in determining the time and manner of one's own death," or, "in common parlance, . . . a right to die." *Compassion in Dying*, 79 F.3d at 793, 799. The court held further that, in the case of mentally competent, terminally ill patients who wish to end their lives by taking a fatal dose of drugs, this liberty interest outweighs the State's "legitimate and countervailing interests, [including] those that relate to the preservation of human life." *Id.* at 79[illegible]-94. Conceding that there is no "liberty interest in receiving 'aid in killing oneself,' " as such, the court couched the issue in wider terms, whether there is "a right to die," to determine "the

time and manner of one's death" or to "hasten[] one's death," because "it is the end and not the means that defines the liberty interest." *Id.* at 801-02.

The circuit court's phrasing of the issue disregards this Court's admonition that " '[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.' " *Reno v. Flores*, 507 U.S. 292, 302 (1993) (quoting Justice Stevens' opinion for a unanimous Court in *Collins v. City of Harker Heights, Texas*, 503 U.S. 115, 125 (1992)). In *Cruzan*, this Court declined to answer the broad question as to whether there is a "right to die," focusing instead on the narrower question of whether "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." 497 U.S. at 277-78.

Precision in defining the issue is also required here. The issue is not whether there is "a right to die," or "a liberty interest in determining the time and manner of one's death" or in "hastening one's death," *Compassion in Dying*, 79 F.3d at 801-02, but "whether the constitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance." *People v. Kevorkian*, 527 N.W.2d 714, 730 n.47 (Mich. 1994) (rejecting right to suicide), *cert. denied sub nom. Kevorkian v. Michigan*, 115 S.Ct. 1795 (1995), *Hobbins v. Kelley*, 115 S.Ct. 1795 (1995).[1]

This Court has enunciated various standards for evaluating both substantive and procedural due process claims. Due process protects those rights which are "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97,

[1] ". . . the common definition of 'suicide' is the intentional killing of oneself by any means, and the temporal proximity of death is irrelevant to the threshold inquiry into whether the constitution encompasses such a right." *Id.* at 725 n.27.

105 (1934). Alternatively, due process secures those rights which are "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937). In another frequently cited formulation, Justice Powell described fundamental liberties as those liberties which are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland, Ohio*, 431 U.S. 494, 503 (1977).

Regardless of the precise wording, each of these tests requires an examination of our history and traditions to assess whether the right (or interest) being asserted has enjoyed legal and societal protection. *Compare Roe v. Wade*, 410 U.S. 113, 140-41 (1973) (recognizing right to abortion where, in the Court's view, there was no unambiguous tradition of legal and social opposition to abortion in English and American law), *with Bowers v. Hardwick*, 478 U.S. 186, 192-94 & nn. 5-7 (1986) (refusing to recognize fundamental right of adult homosexuals to engage in consensual acts of sodomy where both English and American law clearly prohibited such conduct for centuries). The Court's reliance on historical tradition in *Bowers* coincided with a less expansive view of its authority "to discover new fundamental rights imbedded in the Due Process Clause." 478 U.S. at 194.

As this Brief demonstrates, there has never been a period in English or American history when suicide (or suicide assistance) was regarded as a "fundamental right," a "protected liberty interest" or even a socially tolerated practice. Perhaps anticipating that its historical survey, 79 F.3d at 806-10, would fail to convince this Court that a right to (or an interest in) suicide (or suicide assistance) can be derived from our history and traditions, the Ninth Circuit, citing *Planned Parenthood v. Casey*, concluded that these factors are no longer controlling or even persuasive in evaluating substantive due process claims. 79 F.3d at 804-06. But that conclusion is unwarranted.

First, in reaffirming *Roe*, the Court in *Casey* stressed the importance of the rule of *stare decisis* and the integrity of the Supreme Court as an institution in the constitutional order. 505 U.S. at 845-46, 854-69. Neither consideration lends any support to the establishment of a heretofore unrecognized constitutional right. Moreover, in reaffirming *Roe*, the Court sought to *end* the "national controversy" over whether abortion should remain a protected right, *id.* at 867, not to *begin* an entirely new debate on the nature and extent of a previously unheard of right.[2]

Second, in *Casey*, the Court referred to abortion as "a unique act," and said that "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." 505 U.S. at 852. If abortion is a "unique act" and "so unique to the law," then *Casey* cannot be cited in support of a liberty interest in committing suicide, which has no affinity with this Court's decisions "afford[ing] constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education," *id.* at 851, which are "deeply rooted in this Nation's history and tradition." *Moore*, 431 U.S. at 503.

Third, in *Casey*, the Court stated that "the essential holding of *Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880. But protection of that core interest differs radically from an asserted interest in self-destruction where not health, but death, is the desideratum.

Fourth, in *Roe*, the Court was able to recognize a right to abortion only after holding that the unborn child is not a person within the meaning of the Fourteenth Amendment. 410 U.S. at 156-59. Nothing in *Roe*, how-

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[2] The Court's reluctance to state in *Casey* whether *Roe* had been correctly decided as an original matter, 505 U.S. at 869, 871, severely limits the usefulness of looking to either *Roe* or *Casey* as an unexplored source of unenumerated rights.

ever, or in any other decision of this Court remotely suggests that a seriously ill patient, regardless of condition and prognosis, is not a constitutional "person" whose life the State has the right to protect. *See Cruzan*, 497 U.S. at 282 n.10 (recognizing State's interest).

Finally, an examination of *Casey's* analysis of how substantive due process claims are to be reviewed reveals that history and tradition remain critical. "[A]djudication of substantive due process claims may call upon the Court in interpreting the Constitution to exercise that same capacity which by tradition courts always have exercised: reasoned judgment." 505 U.S. at 849. But exercise of that judgment does not allow the Justices "to invalidate state policy choices with which [they] disagree." *Id.* The Court's reliance in *Casey* on Justice Harlan's dissent in *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds), *Casey* 505 U.S. at 849-50, makes it clear that in evaluating original claims of constitutional right, recourse to our history and traditions is still necessary. Thus, this Court must decide whether "the asserted right to commit suicide arises from a rational evolution of tradition, or whether recognition of such a right would be a radical departure from historical precepts." *People v. Kevorkian*, 527 N.W.2d at 730.

II. THE COMMON LAW OF ENGLAND, AS RECEIVED BY THE AMERICAN COLONIES, PROHIBITED SUICIDE AND ATTEMPTED SUICIDE.

An understanding of the development of the common law crime of suicide in England is critical to any analysis of the status of suicide in American colonial law.[a] More

[a] Much of what follows in this and the following argument draws upon the research set forth in Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone and Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 DUQUESNE L. REV. 1 (1986) (hereinafter, *Marzen*). Although the Ninth Circuit repeatedly cited the *Marzen* article in its historical survey (79 F.3d at 807-10 & nn. 23-24, 27, 33-37, 39-40, 42-44), it misstated many of its findings and ignored its conclusion that "the weight of authority in the United States, from colonial days through at least the 1970's[,] has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide," *Marzen*, 24 DUQUESNE L. REV. at 100. *See Compassion in Dying*, 85 F.3d 1440, 1445 & n.14 (9th Cir. 1996) (O'Scannlain, J., dissenting from order rejecting request for rehearing *en banc* by the full court).

than 700 years ago, the thirtenth-century commentator Bracton wrote, "Just as a man may commit felony by slaying another so he may do so by slaying himself, the felony is said to be done to himself [*felo de se*]." 2 H. de Bracton (c. 1250), ON THE LAWS AND CUSTOMS OF ENGLAND (S. Thorne trans. 1968) 423 (BRACTON). If the suicide was committed to avoid punishment for a crime he had committed, all of his property—real and personal—was forfeited to the King. *Id.* at 366, 423-24. But if "a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . he may have a successor, but his movable goods are confiscated. He does not lose his inheritance, only his movable goods." *Id.* at 424. His heirs could inherit his real property (because he had not committed suicide to avoid punishment for committing a crime) but his personal property was confiscated by the Crown. "The principle that suicide of a sane person, for whatever reason, was a punishable felony was thus introduced into English common law." *Marzen*, 24 DUQUESNE L. REV. at 59. But no penalty applied to the suicide of one who was not sane. "[A] madman bereft of reason[,]" "the deranged, the delirious and the mentally retarded" or "one labouring under a high fever" do not commit felony *de se* "nor do such persons forfeit their inheritance or their chattels, since they are without sense and reason and can no more commit an *injuria* or a felony than a brute animal." BRACTON at 424.

Bracton's contemporaries agreed that suicide was a crime at common law. The commentator known as Brit-

ton wrote that "where a man is a felon of himself, his chattels shall be adjudged ours [the King's], as the chattels of a felon, but his inheritance shall descend entire to his heirs." I Britton, Bk. I, ch. VIII (F. Nicols trans. 1865) (reprinted 1983 W.W. Gaunt) 39. Fleta, writing near the end of the thirteenth century, provided a fuller treatment of the subject:

> Just as a man may commit felony in slaying another, so he may in slaying himself; for if one who has lately slain a man or has committed some like act whence felonies arise, conscious of his crime and in fear of judgement, slay himself in any fashion, his goods accrue to the Crown nor may he have any other heir than the lord of the fee. But should anyone slay himself in weariness of life or because he is unable to support some bodily pain, he shall have his son for his heir, but his movable goods will be confiscate. Those, too, who cast themselves down from a height or drown themselves likewise have heirs, provided they have committed no felony. Similarly, madmen and those who are frenzied, childish, deranged or are suffering from high fever, although they kill themselves, do not commit felony or forfeit their inheritance or chattels, because they lack sense and reason. Their wives, moreover, should receive their dowers.

Fleta (c. 1290), Bk. I, ch. XXXIV, *"Of Suicides,"* Publications of the Selden Society, Vol. 72, p. 89 (1955).

In 1628, Sir Edward Coke published his classic INSTITUTES. In his THIRD INSTITUTE, Coke classified suicide as a form of murder. *"Felo de se* is a man or woman, which being *compos mentis*, of sound memory, and of the age of discretion, killeth himself, which being lawfully found by the oath of twelve men, all the goods and chattels of the party so offending are forfeited" E. Coke, THIRD INSTSTUTE OF THE LAWS OF ENGLAND 54 (1644 ed.). Like his predecessors, Coke noted an exception for persons who had killed themselves while insane. "If a man lose his memory by the rage of sickness or infirmity,

or otherwise, and kill himself while he is not *compos mentis,* he is not *felo de se*: for as he cannot commit murder upon another, so in that case he cannot commit murder upon himself." *Id.* According to Coke, a *felo de se* forfeited only his goods and chattels *Id.* at 55.

In 1716, the first edition of William Hawkins' A TREATISE OF THE PLEAS OF THE CROWN was published. Noting that "our Laws have always had . . . an Abhorrence of this Crime," Hawkins' analysis of "Homicide against a Man's own Life" largely followed Coke. Wm. Hawkins, 1 A TREATISE OF THE PLEAS OF THE CROWN (1716) 67-68. Hawkins rejected the prevailing "Notion" that anyone who kills himself must be mentally incompetent, *id.* at 67, and condemned the killing of another person with his consent or at his request, as well as suicide pacts. *Id.* at 68.

In 1736, Sir Matthew Hale's work, HISTORY OF THE PLEAS OF THE CROWN, was published. Like Hawkins, Hale reflected Coke's views on the criminality of suicide at common law. M. Hale, 1 HISTORY OF THE PLEAS OF THE CROWN, Ch. XXXI, *"Concerning homicide and first of self-killing or* felo de se," (1736) at 411-12. In accord with the earlier commentators, Hale stated, "If he lose his memory by sickness, infirmity, or accident, and kills himself he is not *felo de se,* neither can he be said to commit murder upon himself or any other." *Id.* at 412. But Hale doubted whether every suicide could be treated as an insane act. *Id.*

In 1803, Sir Edward East published his PLEAS OF THE CROWN. East described anyone "who wilfully . . . causes his own death" as a *"felo de se."* E. East, 1 PLEAS OF THE CROWN (1803), ch. V, § 5, at 219 (1972 reprint). Calling suicide "an heinous offence," East said that "he who voluntarily kills himself is with respect to the public as criminal as one who kills another. It is equally an offence against the fundamental law of society, which is protection." *Id.*

Sir William Blackstone summarized the law of *felo de se* in his classic eighteenth century commentaries. Characterizing suicide as "[s]elf-murder," Blackstone reiterated the common law's condemnation of suicide as "among the highest crimes, making it a peculiar species of felony, a felony committed on one's self." 4 Blackstone, COMMENTARIES ON THE LAWS OF ENGLAND 189 (1769). Like Hawkins and Hale, Blackstone criticized the tendency of coroner's juries to find "that the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal *non compos,* as well as the self-murderer." *Id.* Blackstone noted that the punishment for suicide at common law was forfeiture of all of the suicide's personal property and ignominious burial in the public way. *Id.* at 190. These punishments were threatened in the hope that a potential suicide's "care for either his own reputation, or the welfare of his family, would be some motive to restrain him from so desperate and wicked an act." *Id.* Nevertheless, Blackstone recommended that the severity of the law be tempered by the power of the sovereign "to execute mercy in judgment." *Id.*

The condemnation of suicide at common law was not limited to the commentators; it was also expressed by the courts. In a case decided more than 400 years ago, an English court described the "quality of the offence" committed by the suicide as "a degree of murder." *Hales v. Petit,* 1 Plowd. 253, 261, 75 Eng. Rep. 387, 399-400 (Queen's Bench 1561-1562). English courts treated both assisted suicide and suicide pacts as forms of homicide.[4]

[4] *See Vaux's Case,* 4 Co. Rep. 44a, 76 Eng. Rep. 992 (1591); *Rex v. Dyson,* Russ. & Ry. 523, 168 Eng. Rep. 930 (1823); *Regina v. Alison,* 8 Car. & P. 418, 173 Eng. Rep. 557 (1838); *Regina v. Jessop,* 16 Cox Cr. Cas. 204 (1887); *Regina v. Stormonth,* 61 J.P. 729 (1897); *Rex v. Abbott,* 67 J.P. 151 (1903). *See also Regina v. Gaylor,* 1 Dears. & B. 288, 169 Eng. Rep. 1011 (1857).

And at common law, *attempted* suicide was a misdemeanor, punishable by fine and imprisonment.[5]

The sparse records available indicate that this was also the law in colonial America. At least nine of the original thirteen colonies prohibited, and in some cases punished, suicide and attempted suicide,[6] though the common law

[5] *See Regina v. Moore,* 3 Car. & K. 319, 175 Eng. Rep. 571 (1852); *Regina v. Doody,* 6 Cox. Crim. Cas. 463 (1854); *Regina v. Burgess,* 9 Cox Crim. Cas. 247, 169 Eng. Rep. 1387 (1862); *Rex v. Mann,* 2 K.B. 107, 83 L.J.K.B. 648 (1914). In its survey of English law, the Ninth Circuit minimized the clear condemnation of suicide (by the mentally competent) enunciated by Bracton and Coke, 79 F.3d at 808-09, relegated Blackstone to an obscure footnote, *id.* at 809 n.38, ignored the other great commentators who unequivocally condemned suicide as criminal and overlooked at least a dozen English cases expressing the law's (*and* society's) disapproval of suicide. Although, in the case of *completed* suicides, juries may have been reluctant to return a verdict that would result in a property forfeiture that would punish only innocent survivors, the guilty verdicts returned against persons who *attempted* suicide, *assisted* suicide or *survived* suicide pacts strongly suggest that English juries experienced no comparable difficulty in applying the law where no forfeiture was at stake.

[6] *Connecticut:* 2 Z. Swift, A SYSTEM OF LAWS OF THE STATE OF CONNECTICUT 304 (n.p. 1796) (reprinted 1972) (noting early instances of ignominious burials); Booth, Woodruff, Mather, Baldwin & Turrill, *Preface* to CONN. GEN. STAT. at vi (1875) (noting State's adoption of common law of England).

Georgia: Life Ass'n of America v. Waller, 57 Ga. 533, 536 (1876) (suicide "a species of crime or wickedness—something wrong; a kind of self-murder" at common law).

Maryland: Pope v. State, 396 A.2d 1054, 1072-74 (Md. 1978) (adoption of common law); Note, *Criminal Liability of Participants in Suicide:* State v. Williams, 5 MD. L. REV. 324, 325-26 (1941) (reporting unappealed trial court decision treating suicide as a common law crime).

Massachusetts: THE GENERAL LAWS AND LIBERTIES OF MASSACHUSETTS COLONY (1672), *reprinted in* THE COLONIAL LAWS OF MASSACHUSETTS 137 (W. Whitmore ed. 1887) (statute mandating ignominious burial for suicide).

North Carolina: State v. Willis, 121 S.E.2d 854 (N.C. 1961) (suicide a criminal act at common law, attempted suicide punishable

penalties generally were abolished after the Revolution.[7] The penalties were abolished, not because society no longer regarded suicide as a wrong (much less as a right), but because of an awareness that punishment could not reach the suicide and a moral sense that it was unfair to punish the suicide's innocent survivors. *See Cruzan*, 497 U.S. at 294 (Scalia, J., concurring).

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as a misdemeanor). *See also* N.C. Laws, ch. XXXI, § VI (1715), *reprinted in* 1 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 18 (John D. Cushing ed. 1984) (adopting common law).

Pennsylvania: Connecticut Mut. Life Ins. Co. v. Groom, 86 Pa. 92, 97 (1878) (describing suicide as "the crime of self-murder"); *Commonwealth v. Wright*, 11 Pa. D. 144 (Ct. Quarter Sess., Phil. County 1902) (criticizing practice of indicting persons "for the common law offence of attempting to commit suicide"); *Elwood v. New England Mut. Life Ins. Co.*, 158 A. 257, 259 (Pa. 1931) (classifying attempted suicide as "a crime infamous at common law," and a successful suicide as "a species of felony").

Rhode Island: THE EARLIEST ACTS AND LAWS OF THE COLONY OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, 1647-1719, at 19, 59 (John D. Cushing ed. 1977) (adopting common law punishments for suicide).

South Carolina: S.C. Acts, No. 253, § VI (Apr. 9, 1706), *reprinted in* 1 THE EARLIEST PRINTED LAWS OF SOUTH CAROLINA, 1692-1734, at 192 (John D. Cushing ed. 1978), (recognizing criminality of suicide at common law).

Virginia: A. Scott, CRIMINAL LAW IN COLONIAL VIRGINIA 108 n.198, 198-99 nn.15-16 (1930) (noting instances of ignominious burial and forfeiture of property).

[7] *See, e.g.*, DEL. CONST. art. 1, § 15 (1792); MD. CONST., Declaration of Rights § 24 (1776); N.H. CONST. pt. 2, art. 89 (adopted 1789); N.J. CONST. of 1776, art. 17; N.C. Laws, ch. XXXI (1787), *reprinted in* 2 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 626 (John D. Cushing ed. 1984); an Act to reform the penal Laws, § 53 (1798), *reprinted in* 2 THE FIRST LAWS OF THE STATE OF RHODE ISLAND 604 (John D. Cushing ed. 1983); Act of Mar. 14, 1848 (Criminal Code), tit. II, ch. XI, §§ 23, 25, 1847-48 Va. Laws 124. Contrary to the understanding of the Ninth Circuit, 79 F.3d at 809, the abolition of common law penalties did *not* mean that suicide had been decriminalized. *See Potts v. Barrett Div., Allied Chem. & Dye Corp.*, 138 A.2d 574, 580 (N.J. Super. 1958); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961); *Wackwitz v. Roy*, 418 S.E.2d 861, 864 (Va. 1992).

III. ALTHOUGH THE PENALTIES FOR SUICIDE AND ATTEMPTED SUICIDE ULTIMATELY FELL INTO DISFAVOR IN AMERICAN LAW, THE STATES HAVE RETAINED A STRONG AND COMPELLING INTEREST IN THE PRESERVATION OF HUMAN LIFE AND IN THE PREVENTION OF SUICIDE.

The common law penalties for suicide were abandoned after the Revolutionary War, and attempted suicide was seldom prohibited[8] and more rarely punised.[9] Nevertheless, suicide was regarded as "*malum in se*" and was often referred to as a "crime," a "wrongful

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[8] At one time or another, eight States prohibited attempted suicide: *Minnesota*: MINN. PENAL CODE, §§ 143, 147 (1885), *codified as* MINN. GEN. STAT. §§ 6428, 6432 (1894), *recodified as* MINN. REV. LAWS, § 4870, *repealed by* an Act of Apr. 20, 1911, ch. 293, § 1, 1911 Minn. Laws 409, 409; *Nevada*: Crimes & Punishments Act of 1911, § 115, *codified as* NEV. REV. LAWS § 6380 (1912), *repealed by* an Act of Mar. 25, 1913, ch. 238, § 1, 1913 NEV. STAT. 362, 362; Act of Mar. 4, 1957, ch. 35, § 1, 1956-57 NEV. STAT. 59, 59-60, *repealed by* an Act of Mar. 31, 1961, ch. 256, § 1, 1961 Nev. Stat. 416, 416; *New Jersey*: Act of May 9, 1957, ch. 34, § 1, 1 N.J. Laws 63, 67 (1957), *codified as* N.J. REV. STAT. § 2A:170-25.6 (Supp. 1967), *repealed by* an Act of Act of Feb. 16, 1972, ch. 450, § 3, 1971 N.J. Laws 1934; *New York*: Act of July 26, 1881, ch. 676, §§ 174, 178, 1881 N.Y. Laws (Vol. 3 Penal Code) at 42-43, *repealed by* an Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193, 1193; *North Dakota*: G. Hand, REV. CODES OF THE TERRITORY OF DAKOTA, PENAL CODE §§ 230, 236 (1877), *repealed by* an Act of Mar. 4, 1967, ch. 108, § 1, 1967 N.D. Sess. Laws 215, 300; *Oklahoma*: Okla. Terr. Stat. 2076 (1890), *repealed by* an Act of Jan. 30, 1976, ch. 6, § 2, 1976 Okla. Sess. Laws 7; *South Dakota*: G. Hand, REV. CODES OF THE TERRITORY OF DAKOTA, PENAL CODE §§ 230, 236 (1877), *recodified as* S.D. CODE, § 13.1903 (1939), *repealed by* an Act of Feb. 17, 1968, ch. 31, § 1, § 13.1901, 1968 S.D. Sess. Laws 47, 47; *Washington*: CRIM. CODE, ch. 249, § 134, 1909 Wash. Laws 11th Sess. 890, 929, codified at REM. & BAL. CODE § 2386 (1910), *repealed by* WASH. CRIM. CODE, 1975, ch. 260, § 9A.92.010(213)-(217) Wash. Laws 817, 866, *codified as* REV. WASH. CODE § 9A.92.010(213)-(217) (1977).

[9] Three courts held that attempted suicide could be charged as a common law crime. *See State v. Carney*, 55 A. 44 (N.J. 1903); *State v. Lafayette*, 188 A. 918 (N.J. Common Pleas 1937); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961).

act," a "grave public wrong," or an act of "moral turpitude," even though it was no longer punishable.[10] Indeed, in a case decided 120 years ago, this Court characterized suicide as "self-murder," and referred to the suicide of a sane person as "an act of criminal self-destruction." *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 286 (1876).

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[10] *See, e.g., McMahan v. State*, 53 So. 89, 90-91 (Ala. 1910); *Pennsylvania Mut. Life Ins. Co. v. Cobbs*, 123 So. 94, 97 (Ala. App. 1929); *Life Ass'n of America v. Waller*, 57 Ga. 533, 536 (1876); *Grand Lodge of Illinois, Indep. Order of Mut. Aid v. Wieting*, 48 N.E. 59, 61-62 (Ill. 1897); *Dickerson v. Northwestern Mut. Life Ins. Co.*, 65 N.E. 694, 696 (Ill. 1902); *Wallace v. State*, 116 N.E.2d 100, 101 (Ind. 1953); *Brown v. Metropolitan Life Ins. Co.*, 7 N.W.2d 21, 24 (Iowa 1943); *Manhattan Life. Ins. Co. v. Beard*, 66 S.W. 35, 37 (Ky. 1902); *Dugan v. Commonwealth*, 333 S.W.2d 755, 756 (Ky. 1960); *Commonwealth v. Mink*, 123 Mass. 422, 426, 428-29 (1877); *Bohaker v. Travelers Ins. Co.*, 102 N.W. 342, 344 (Mass. 1913); *Hale v. Life Indem. & Inv. Co.*, 63 N.W. 1108, 1108 (Minn. 1895); *Shipman v. Protected Home Circle*, 67 N.E. 83, 85 (N.Y. 1903); *Benard v. Protected Home Circle*, 146 N.Y.S. 232, 235 (App. Div. 1914); *State v. Willis*, 121 S.E.2d 854, 855-57 (N.C. 1961); *Wyckoff v. Mut. Life Ins. Co. of N.Y.*, 147 P.2d 227, 229 (Or. 1944); *Elwood v. New England Mut. Life Ins. Co.*, 158 A. 257, 258-59 (Pa. 1931); *State v. Levelle*, 13 S.E. 319, 321 (S.C. 1891), *overruled on other grounds, State v. Torrence*, 406 S.E.2d 315 (S.C. 1991); *Phadenhauer v. Germania Life Ins. Co.*, 54 Tenn. (7 Heisk.) 567, 576 (1872); *State ex rel. Swann v. Pack*, 527 S.W.2d 99, 113 (Tenn. 1975), *cert. denied*, 424 U.S. 954 (1975); *Plunkett v. Supreme Conclave, Improved Order of Heptasophs*, 55 S.E. 9, 10-11 (Va. 1906); *Patterson v. Natural Premium Mut. Life Ins. Co.*, 75 N.W. 980, 983 (Wis. 1898).

In its highly selective use of historical materials, the Ninth Circuit ignored twenty-two decisions from sixteen American jurisdictions (most of which were cited in *Marzen*) condemning suicide and, instead, focused on one, isolated New Jersey Supreme Court decision from 1901 which, in *dicta*, appeared to excuse suicide, at least in some instances. *See Compassion in Dying*, 79 F.3d at 809-10 (quoting *Campbell v. Supreme Conclave Improved Order Heptasophs*, 49 A. 550, 553 (N.J.L. 1901)). The court failed to note that later New Jersey opinions expressly rejected *Campbell's* approbation of suicide. *See State v. Carney*, 55 A. 44 (N.J. 1903); *Potts v. Barrett Div., Allied Chem. & Dye Corp.*, 138 A.2d 574, 580 (N.J. Super. 1958).

Regardless of the status of suicide itself, most States prohibited *assisted* suicide. By the time that the Fourteenth Amendment was approved in 1868, at least twenty-one of the then thirty-seven States, including eighteen of the thirty ratifying States, banned assisted suicide, either as a statutory[11] or common law offense.[12] Whatever may have been the common law ra-

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[11] *Arkansas:* Act of Feb. 16, 1838, *printed as* ARK. REV. STAT. ch. XLIV, div. III, art. II, § 4, at 240 (1838); *Florida:* Act of Aug. 6, 1868, ch. 1637 (No. 13), subchap. 3, § 9, 1868 Fla. Laws 61, 64; *Kansas:* KAN. TERR. STAT. ch. 48, § 8 (1855); *Minnesota:* MINN. TERR. REV. STAT. ch. 100, § 9, at 493 (1851); *Mississippi:* Act of Feb. 15, 1839, ch. 66, tit. 3, § 7, 1839 Miss. Laws 102, 112, *codified as* MISS. CODE ch. 64, art. 12, tit. 3, § 7, at 958 (Hutchinson 1849); *Missouri:* Act of Mar. 20, 1835, art. II, *codified as* MO. REV. STAT. CRIMES & PUNISHMENTS, art. II, § 8, at 168 (1835); *New York:* 2 N.Y. REV. STAT. pt. IV, ch. I, tit. I, art. 1, § 7 at 661 (1829); *Oregon:* OR. GEN. LAWS 1845-1864 (Deady 1866), CODE OF CRIM. PROC. § 508 at 528; *South Carolina:* 1 THE EARLIEST PRINTED LAWS OF SOUTH CAROLINA 1692-1734, at 190 (John D. Cushing ed. 1978) (statute condemning suicide as a felony and, by implication, *assisted* suicide); *Wisconsin:* REVISED STAT. OF THE STATE OF WIS. ch. 133, § 9 (Albany, N.Y. 1849), *codified as* REV. STAT. OF WIS. ch. 164, § 9 (1858).

[12] *Alabama:* Alabama adopted the common law of crimes, including the law of homicide. ALA. DIGEST, tit. 17, ch. 1, § 45, at 214 (H. Toulmin ed. 1823); PENAL CODE, No. 138, ch. 3, § 2, 1840-41 ALA. ACTS 122 (*codified as* Supplement to AIKEN'S DIGEST PENAL CODE, ch. 3, § 2, at 210 (A. Meek ed. 1836-41)). For the modern statutory codification of common law crimes, *see* ALA. CODE § 13A-6-3 (1994) and *Commentary*. Since "[e]very murder at common law is murder under our statutes," *McMahan v. State*, 53 So. 89, 90 (Ala. 1910), suicide was a felony even though no punishment could be attached. *Id.* at 90-91 ("intentional self-destruction" is "felo de se"). Accordingly, *assisted* suicide would have been criminal, also. *See also Crook v. State*, 160 So.2d 884, 893 (Ala. 1963): "Suicide is murder at Common Law. . . . An agreement compassing it is a criminal conspiracy. If one of the conspirators dies . . . the survivor—if he contributed to the suicide whether present or not—can legitimately be tried for murder."

Connecticut: Connecticut also adopted the common law of crimes. *See* Booth, Woodruff, Mather, Baldwin & Turrill, *Preface to* CONN. GEN. STAT. at vi (1875). Persuading, provoking or counseling

tionale for prohibiting suicide, the States have retained a strong interest in protecting the lives of their citizens. That interest is currently manifested in several ways.

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another to commit suicide was treated as murder. 2 Z. Swift, A DIGEST OF THE LAWS OF THE STATE OF CONNECTICUT 270 (New Haven 1823).

Georgia: A post-Reconstruction case referred to suicide as "something more than self-sought and self-inflicted death. It is a species of crime or wickedness—something wrong; a kind of self-murder." *Life Ass'n of America v. Waller*, 57 Ga. 533, 536 (1876). This language suggests that *assisted* suicide would have been criminal, too.

Kentucky: In 1904, the Kentucky Court of Appeals held that suicide was a common law felony and that one could be charged and convicted for advising or assisting in the commission of a suicide. *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904).

Maryland: From its earliest days, Maryland adopted the common law of crimes. *See Pope v. State*, 396 A.2d 1054, 1072-74 (Md. 1978) (recognizing common law crime of misprision of felony); *Gladden v. State*, 330 A.2d 176 (Md. 1974) (adopting common law "transferred intent" rule); *State v. Buchanan*, 5 H. & J. 317 (1821) (adopting common law crime of conspiracy). Both suicide and assisted suicide were crimes at common law. An unappealed trial court decision in 1940 upheld the conviction of the survivor of a suicide pact for second-degree murder, essentially holding that active assistance in committing suicide is a form of homicide. *See* Note, *Criminal Liability of Participants in Suicide:* State v. Williams, 5 MD. L. REV. 324 (1941).

Massachusetts: Commonwealth v. Bowen, 13 Mass. 356 (1816) (holding that one prisoner who assisted another prisoner in hanging himself in jail could be charged with murder); *Commonwealth v. Mink*, 123 Mass. 422, 429 (1877) (reviewing cases on suicide and attempted suicide and concluding that while not "technically a felony in this Commonwealth," suicide was nevertheless "unlawful and criminal as *malum in se*," and that "any attempt to commit it is likewise unlawful and criminal").

Michigan: From its earliest days as a territory, Michigan adopted the common law of crimes, in addition to particular statutory crimes. *See* CASS CODE OF 1816, Crimes § 58, *reprinted in* 1 MICH. TERR. LAWS 132-33 (1871). For the modern statutory codification of common law crimes, *see* MICH. COMP. LAWS ANN. § 750.505 (West 1991). In an 1876 decision, the Michigan Supreme Court recognized that the suicide of sane person was a crime at common law. *See John Hancock Mut. Life Ins. Co. v. Moore*, 34

First, almost all of the States (forty-six States) forbid assisted suicide, either by an express statute [13] or by ap-

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Mich. 41, 45 (1876). In *People v. Roberts*, 178 N.W. 690 (Mich. 1920), *overruled in part, People v. Kevorkian*, 527 N.W.2d at 733-39, the Michigan Supreme Court upheld a murder conviction of a man who provided poison to his wife who committed suicide. In *Kevorkian*, the Michigan Supreme Court held that assisted suicide was punishable as a common law crime even in the absence of special legislation. *Id.* at 739.

North Carolina: In 1961, the North Carolina Supreme Court, noting that the State had adopted the common law of crimes (*see* N.C. GEN. STAT. § 14-1(1) (1993)), held that attempted suicide was an indictable misdemeanor. *State v. Willis*, 121 S.E.2d 854 (N.C. 1961). The court expressly held that one who "aids and abets another in . . . self-murder is amenable to the law." *Id.* at 856-57. After independence, North Carolina readopted the common law. *See* N.C. LAWS, ch. V, § II (1778), *reprinted in* 1 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 351 (John D. Cushing ed. 1984).

Pennsylvania: In 1878, the Pennsylvania Supreme Court defined suicides as "the crime of self-murder" in "legal acceptation and in popular use." *Connecticut Mut. Life Ins. Co. v. Groom*, 86 Pa. 92, 97 (1878). As a State that adopted common law crimes, *assisting* suicide would have been a criminal offense.

Tennessee: Tennessee adopted the common law. *See State v. Alley*, 594 S.W.2d 381, 382 (Tenn. 1980). In 1872, the Tennessee Supreme Court referred to suicide "a crime of the highest grade." *Phodenhauer v. Germania Life Ins. Co.*, 54 Tenn. (7 Heisk.) 567, 576 (1872). Thus, *assisted* suicide also would have been unlawful.

Virginia: Virginia adopted the common law of crimes. *See* A. Scott, CRIMINAL LAW IN COLONIAL VIRGINIA 27 (1930); VA. CODE ANN. § 18.2-16 (1996); *Plunkett v. Supreme Conclave, Improved Order of Heptasophs*, 55 S.E. 9, 11 (Va. 1906) (referring to suicide as a "crime"). *See also Wackwitz v. Roy*, 418 S.E.2d 861, 864 (Va. 1992) ("[s]uicide . . . remains a common law crime in Virginia as it does in a number of other common-law states").

[13] Thirty-five States have enacted statutes banning assisted suicide. ALASKA STAT. § 11.41.120(a)(2) (Michie 1989); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (West Supp. 1995); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. § 18-3-104(1)(b) (Supp. 1995); CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1994); DEL. CODE ANN. tit. 11, § 645 (1995); FLA. STAT. ANN. § 782.08 (West 1992); GA. CODE ANN. § 16-5-5(b) (1996); ILL. COMP. STAT. ANN. CH. 720,

plication of general homicide or common law principles.[14] Although suicide assistance is not as common as suicide

§ 5/12-31(a)(2) (Smith-Hurd Supp. 1996); IND. CODE ANN. § 35-42-1-2.5(b) (Michie Supp. 1996); Iowa S.F. 2066, *to be codified as* IOWA CODE § 707A.2 (Supp. 1996); KAN. STAT. ANN. § 21-3406 (1995); KY. REV. STAT. ANN. § 216.302 (Michie 1995); LA. REV. STAT. ANN. § 14:32.12 (West Supp. 1996); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983); MINN. STAT. ANN. § 609.215 (West 1987 and Supp. 1996); MISS. CODE ANN. § 97-3-49 (1994); MO. ANN. STAT. § 565.023.1(2) (West Supp. 1996); MONT. CODE ANN. § 45-5-105 (1995); NEB. REV. STAT. ANN. § 28-307 (Michie 1995); N.H. REV. STAT. ANN. § 630.4 (1996); N.J. STAT. ANN. § 2C:11-6 (West 1995); N.M. STAT. ANN. § 30-2-4 (Michie 1994); N.Y. PENAL LAW §§ 120.30, 125.15(3) (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Supp. 1995); OKLA. STAT. ANN. tit. 21, §§ 813, 814, 815 (West 1983); OR. REV. STAT. § 163.125(1)(b) (1993) (although Oregon allows physician-assisted suicide under certain circumstances, *see* OR. REV. STAT. § 127.800 *et seq.* (1996), assisted suicide remains generally illegal); PA. CONS. STAT. ANN. tit. 18, § 2505(b) (West 1983); R.I. Pub. Act 96-133, *to be codified as* R.I. GEN. STAT. tit. 11, ch. 60; S.D. CODIFIED LAWS ANN. § 22-16-37 (Michie 1988); TENN. CODE ANN. § 39-13-216 (Supp. 1995); TEX. PENAL CODE ANN. § 22.08 (West 1994); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1996).

[14] *Idaho:* IDAHO CODE § 18-303 (1987) (adopting common law crimes).

Ohio: Blackburn v. State, 23 Ohio St. 146 (1872) (man convicted of murder for preparing poisonous concoction and giving it to his wife, who drank it intending to kill herself).

South Carolina: State v. Levelle, 13 S.E. 319, 321 (S.C. 1891) ("suicide is an unlawful act, an act *malum in se*, and is a felony"). Since suicide was a felony, *assisted* suicide would have been criminal, also. *See also State v. Jones*, 67 S.E. 160, 162, 165 (S.C. 1910). For the modern statutory codification of common law crimes, *see* S.C. CODE ANN. § 16-1-110 (Law Co-op. Supp. 1995).

Vermont: VT. STAT. ANN. tit. 1, § 271 (1996) (adopting common law). *See State v. Stanislaw*, 573 A.2d 286, 289 (Vt. 1990) (recognizing common law crimes).

West Virginia: State v. General Daniel Morgan Post No. 548, 107 S.E.2d 353, 357 (W. Va. 1959) (adopting common law crimes). For *Alabama, Maryland, Massachusetts, Michigan, North Carolina* and *Virginia, see* the authorities cited in n.12, *supra*.

itself, the States do enforce their assisted suicide laws.[15] Moreover, suicide assistance is often prosecuted as a form of homicide, independent of any assisted suicide statute, where one person actively assists another in killing himself.[16]

Second, nearly one-half of the States allow both private and public actors to use nondeadly force to thwart suicide attempts.[17] Third, all States provide for the tem-

[15] *See, e.g., Hinson v. State*, 709 S.W.2d 106 (Ark. App. 1986); *In re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *In re Application of Keddie*, 1990 WESTLAW 96595 (Del. Super. 1990) (noting plea of guilty to promoting a suicide); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991); *Commonwealth v. Swartzentruver*, 389 A.2d 181 (Pa. Super. 1978); *Chanslor v. State*, 697 S.W.2d 393 (Tex. Cr. App. 1985) (noting that defendant could have been charged with assisted suicide in obtaining poison to give to his wife). *See also Wall Street Journal*, May 1, 1996, A18 (reporting man's plea of guilty to attempted manslaughter for assisting his wife in committing suicide).

[16] *See, e.g., People v. Cleaves*, 280 Cal. Rptr. 146 (Ct. App. 1991) (second degree murder); *State v. Marti*, 290 N.W.2d 570 (Ia. 1980) (involuntary manslaughter); *Persampieri v. Commonwealth*, 175 N.E.2d 387 (Mass. 1961) (involuntary manslaughter); *State v. Bier*, 591 P.2d 1115 (Mont. 1979) (negligent homicide); *State v. Sexson*, 869 P.2d 301 (N.M. 1994) (murder); *People v. Duffy*, 595 N.E.2d 814 (N.Y. 1992) (manslaughter).

[17] See ALA. CODE § 13A-3-24(4) (1994); ALASKA STAT. § 11.81.430(a)(4) (Michie Supp. 1989); ARIZ. REV. STAT. ANN. § 13-403(4) (West 1989); ARK. CODE ANN. § 5-2-605(4) (Michie 1993); COLO. REV. STAT. § 18-1-703(1)(d) (West 1990); CONN. GEN. STAT. ANN. § 53a-18(4) (West 1994); DEL. CODE ANN. tit. 11, § 467(9) (1995); HAW. REV. STAT. § 703-308(1) (1985); KY. REV. STAT. § 503.100(1)(a) (Michie 1990); ME. REV. STAT. ANN. tit. 17-A, § 106(6) (West 1983); MINN. STAT. ANN. § 609.06(8) (West 1987); MO. ANN. STAT. § 563.061(5) (West 1979); NEB. REV. STAT. § 28-1412(7) (Michie 1995); N.H. REV. STAT. § 627:6(VI) (1996); N.J. STAT. ANN. § 2C:3-7(e) (West 1995); N.Y. PENAL LAW § 35.10(4) (McKinney 1987); N.D. CENT. CODE § 12.1-05-05(5) (1985); OKLA. STAT. ANN. tit. 21, § 643(6) (West 1996); OR. REV. STAT. § 161.205(4) (1993); PA. CONS. STAT. ANN. tit. 18, § 508(d) (West 1983); TENN. CODE ANN. § 39-11-613 (1991); TEX. PENAL CODE ANN. § 9.34(a) (West 1994); WIS. STAT. ANN. § 939.48(5) (West 1996).

porary involuntary commitment of individuals who, as a result of mental disease or illness, may harm themselves.[18] Finally, despite occasional instances of jury nullification or discretionary decisions not to prosecute, acts of "mercy-killing" or active voluntary euthanasia always have been considered as homicide. The law does not accept the consent of the victim as a defense to a charge of homicide,[19] nor benevolent motive as an excuse.[20]

In light of this overwhelming legislative and judicial consensus,[21] which the Ninth Circuit largely ignored, it

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[18] *See, e.g.*, N.Y. MENTAL HYG. LAW, § 9.01 *et seq.* (McKinney 1996); WASH. REV. CODE ANN. § 71.05.020 *et seq.* (West 1992).

[19] *See, e.g., Gospodareck v. Stat*, 666 So.2d 835, 842 (Ala. Cr. App. 1993); *People v. Matlock*, 336 P.2d 505 (Cal. 1959); *In re Thomas C.*, 228 Cal. Rptr. 430 (Ct. App. 1986); *Ragan v. State*, 599 So.2d 276 (Fla. Dist. Ct. 1992); *Gentry v. State*, 625 N.E.2d 1268 (Ind. App. 1994); *State v. Cobb*, 625 P.2d 1133, 1135-36 (Kan. 1981); *State v. Ludwig*, 70 Mo. 412, 415 (1879); *State v. Fuller*, 278 N.W.2d 756, 761 (Neb. 1979); *Edinburgh v. State*, 896 P.2d 1176, 1178-80 (Okla. Cr. App. 1995); *State v. Bouse*, 264 P.2d 800, 812 (Or. 1953), *overruled on other grounds, State v. Fischer*, 376 P.2d 418 (Or. 1962), *State v. Brewton*, 395 P.2d 874 (Or. 1964); *Turner v. State*, 108 S.W. 1139, 1141 (Tenn. 1907); *Goodin v. State*, 726 S.W.2d 956, 957-58 (Tex. Cr. App. 1987); *Martin v. Commonwealth*, 37 S.E.2d 43, 47 (Va. 1946). *See also State v. Mays*, 307 S.E.2d 655 (W. Va. 1983).

[20] *People v. Conley*, 411 P.2d 911, 918 (Cal. 1966) ("one who commits euthanasia bears no ill will toward his victim and believes [that] his act is morally justified . . . nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief"); *Gilbert v. State*, 487 So.2d 1185, 1190 (Fla. Dist. Ct. App. 1986), *rev. denied*, 494 So.2d 1150 (Fla. 1986); *Eichner v. Dillon*, 426 N.Y.S.2d 517, 533 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 420 N.E.2d 64 (N.Y. 1981). Anecdotal evidence and polling data that some physicians may assist their patients in killing themselves, *Compassion in Dying*, 79 F.3d at 811 & nn.54-59, does not reflect societal acceptance of such conduct, especially where the conduct is difficult to detect and prosecute.

[21] The Model Penal Code prohibits assisted suicide, even though the Code does not criminalize either suicide or attempted suicide. *See* MODEL PENAL CODE § 210.5(2). In their *Comment*, the drafters said that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." *Id.* at 100.

cannot plausibly be argued that a right to commit suicide (or suicide assistance) under any circumstances is "deeply rooted in this Nation's history and traditions," *Moore v. City of East Cleveland, Ohio*, 431 U.S. at 503, or that it is "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. at 325. It would be "an impermissibly radical departure from existing tradition, and from the principles that underlie that tradition, to declare that there is such a fundamental right protected by the Due Process Clause." *Kevorkian*, 527 N.W.2d at 733.

IV. BOTH THE SECOND CIRCUIT AND THE NINTH CIRCUIT ERRED IN EQUATING SUICIDE WITH THE REFUSAL OF UNWANTED LIFE-SUSTAINING MEDICAL TREATMENT.

The key error of both the Second Circuit's equal protection analysis and the Ninth Circuit's due process analysis was to equate suicide, a crime at common law, with the refusal of unwanted medical care, a right protected by the common law and the Constitution. *See Quill*, 80 F.3d at 725-31; *Compassion in Dying*, 79 F.3d at 820-24. They are not equivalent.

> [W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining treatment simply permits life to run its course, unencumbered by contrived intervention. Put another way, suicide frustrates the natural course by introducing an outside agent to accelerate death, whereas the refusal or withdrawal of life-sustaining medical treatment allows nature to proceed, i.e., death occurs because of the underlying condition.
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> * * * *
>
> [P]ersons who opt to discontinue life-sustaining medical treatment are not, in effect, committing suicide. There is a difference between choosing a natural death summoned by an uninvited illness or

> calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.

People v. Kevorkian, 527 N.W.2d at 728-29.

Virtually without exception, state legislators and both state and federal courts have recognized the distinction between directly *causing* death by an affirmative act ending life and *allowing* death to occur by withholding or withdrawing life-sustaining medical treatment. Forty-seven States expressly disapprove of mercy killing, suicide and assisted suicide in either their natural death acts/living will statutes,[22] or their durable power of attorney for

[22] ALA. CODE § 22-8A-10 (1990); ALASKA STAT. § 18.12.080(f) (Michie 1994); ARIZ. REV. STAT. ANN. § 36-3210 (West. Supp. 1995); ARK. CODE ANN. § 20-17-210(g) (Michie 1991); CAL. HEALTH & SAFETY CODE § 7191.5(g) (West Supp. 1996); COLO. REV. STAT. § 15-18-112(1) (West 1987); FLA. STAT. ANN. § 765.309 (1) (West Supp. 1996); GA. CODE ANN. § 31-32-11(b) (1996); HAW. REV. STAT. § 327D-13 (Supp. 1992); ILL. COMP. STAT. ANN. ch. 755, § 35/9(f) (Smith-Hurd 1992); IND. CODE ANN. § 16-36-4-19 (Michie 1993); IOWA CODE ANN. § 144A.11.6 (West 1989); KAN. STAT. ANN. § 65-28,109 (1992); KY. REV. STAT. ANN. § 311.639 (Michie 1995); LA. REV. STAT. ANN. § 40:1299.58.10(A) (West 1992); ME. REV. STAT. ANN. tit. 18-A, § 5-813(c) (West Supp. 1995); MD. HEALTH-GEN. CODE ANN. § 5-611(c) (1994); MINN. STAT. ANN. § 145B.14 (West Supp. 1996); MISS. CODE ANN. § 41-41-117(2) (1993); MO. ANN. STAT. § 459.055(5) (West 1992); MONT. CODE ANN. § 50-9-205(7) (1995); NEB. REV. STAT. ANN. § 20-412(7) (Michie 1995); NEV. REV. STAT. ANN. § 449.670(2) (Michie 1991); N.H. REV. ANN. § 137-H:13 (1996); N.C. GEN. STAT. § 90-320(b) (1993); N.D. CENT. CODE § 23-06.4-01 (1991); OHIO REV. CODE ANN. § 2133.12(D) (Anderson Supp. 1995); OKLA. STAT. ANN. tit. 63, § 3101.12(G) (West Supp. 1996); PA. CONS. STAT. ANN. tit. 20, § 5402(b) (West Supp. 1996); R.I. GEN. LAWS § 23.4.11-10(f) (Supp. 1995); S.C. CODE ANN. § 44-77-130 (Law. Co-op. Supp. 1996); S.D. CODIFIED LAW ANN. § 32-12D-20 (Michie 1994); TEX. HEALTH & SAFETY CODE ANN. § 672.020 (West 1992); UTAH CODE ANN. § 75-2-1118 (1993); VA. CODE ANN. § 54.1-2990 (Michie 1994); WASH. REV. CODE ANN. § 70.122-100 (West Supp. 1996); W. VA. CODE § 16-30-10 (1995); WIS. STAT. ANN. § 154.11 (6) (West 1989); WYO. STAT. § 35-22-109 (Michie 1994).

health care acts [23] or both.[24]

Moreover, the majority's conclusion in *Compassion in Dying* "that there is no constitutionally permissible distinction between suicide and refusing medical treatment . . . ignores a long line of judicial decisions that recognize the distinction." 85 F.3d at 1444 (O'Scannlain, J., dissenting from order rejecting request for rehearing *en banc* by the full court). In *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the landmark "right-to-die" case, the New Jersey Supreme Court, in authorizing the parents of Karen Ann Quinlan to remove her from a ventilator, was careful to distinguish withdrawal of life support from homicide and suicide "We would see a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, in the fact of irreversible, painful and certain imminent death." *Id.* at 665. The court noted further that "there would be no criminal homicide" in removing the ventilator, explaining that "the ensuing death would not be homicide but rather expiration from existing natural causes." *Id.* at 669-70. In *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), the Massachusetts Supreme Judicial Court concurred:

[23] Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981); IDAHO CODE § 39-152 (Supp. 1996) (DNR orders); ILL. COMP. STAT. ANN. ch. 755, § 40/50 (Smith-Hurd 1992); IND. CODE ANN. §§ 16-36-1-12(c), 16-36-1-13 (Michie 1993), *see also* § 30-5-5-17(b) (Michie Supp. 1996); IOWA CODE ANN. § 144B.12.2 (West Supp. 1996); MASS. GEN. LAWS ANN. ch. 201D, § 12 (West Supp. 1996); MICH. COMP. LAWS ANN. § 700.496(20) (West 1995); N.Y. PUB. HEALTH LAW § 2989(3) (McKinney 1993); N.D. CENT. CODE § 23-06.5-01 (1991); R.I. GEN. LAWS 23-4.10-9(f) (Supp. 1995); WYO. STAT. § 3-5-211 (Michie Supp. 1996).

[24] *See* notes 22 and 23, *supra*. *See also* CONN. GEN. STAT. ANN. § 19a-575 (West Supp. 1996) (form declaration); N.J. STAT. ANN. § 26:2H-54(d), -(e) (West 1996) (legislative findings); N.M. STAT. ANN. § 24-7A-13(C) (Michie Supp. 1995).

> In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes, the patient did not set the death producing agent in motion with the intent of causing his own death.

Id. at 426 n.11. *See also Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("a necessary distinction exists between a person suffering from a life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her demise and attempts to enlist the assistance of others); *Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("[a] death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient").

Almost every court recognizing a right to refuse medical treatment has expressly distinguished removal of life support from suicide, and has drawn a clear distinction between *allowing* death to occur by passive means (refusing life-sustaining treatment) and *causing* death by active means (killing the patient by a direct act that ends his life).[25] No court, with the exception of those courts

[25] *See also Rasmussen v. Fleming*, 741 P.2d 674, 685 (Ariz. 1987); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Ct. App. 1986) (quadriplegic's "decision to let nature take its course is not equivalent to an election to commit suicide with real parties aiding and abetting therein"); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (Ct. App. 1984); *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Ct. App. 1983); *McConnell v. Beverly Enterprises, Inc.*, 553 A.2d 596, 605 (Conn. 1989); *In re Guardianship of Browning*, 568 So.2d 4, 14 (Fla. 1990) ("suicide is not an issue when . . . the discontinuance of life support 'in fact will merely result in [the patient's] death, if at all, from natural causes'") (citing *Satz v.*

whose decisions are under review here, has held otherwise. As these cases demonstrate, suicide cannot be equated with the refusal of medical treatment. They are different in two key respects: First, in the case of removing life-sustaining treatment, there is no intent to end life, but only the knowledge that death may result. Second, regardless of whether there is an intent to end life, the removal of life support is not the actual cause of death; rather, death results from natural causes (*e.g.*, an underlying pathology that renders a patient unable to breathe or eat without mechanical assistance). These distinctions fully justify treating assisted suicide differently from the refusal of unwanted life-sustaining medical treatment. *See FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-16 (1993). As the New York State Force Report on Life and the Law noted:

> The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent

Perlmutter, 362 So.2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980); *In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989); *In re Lawrance*, 579 N.E.2d 32, 40 n.4 (Ind. 1991); *De Grella by and through Parrent v. Elston*, 858 S.W.2d 698, 707 (Ky. 1993) ("'[m]ercy killing' and 'euthanasia' or any other 'affirmative or deliberate act to end life' are fundamental violations of the common law") (citation omitted); *In re P.V.W.*, 424 So.2d 1015, 1022 (La. 1982); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass. 1992), *cert. denied sub nom. Doe v. Gross*, 505 U.S. 950 (1992); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 638 (Mass. 1986); *In re Rosebush*, 491 N.W.2d 633, 636 n.2 (Mich. App. 1992); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) ("there is a substantial difference between the attitude of a person desiring non-interference with the natural consequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Farrell*, 529 A.2d 40, 411 (N.J. 1987); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 10 (1980); *In re Fiori*, 673 A.2d 905, 910 (Pa. 1996); *In re Guardianship of Grant*, 747 P.2d 445, 455 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988); *In re L.W.*, 482 N.W.2d 60, 71 (Wis. 1992).

> with society's basic conception of personal dignity. . . . It is this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.

WHEN DEATH IS SOUGHT 71.

The decision respondents urge upon this Court not only would overturn the assisted suicide statutes throughout the States, but also would undermine the right of public and private actors to intervene to prevent suicide and jeopardize the authority of public health officials to institutionalize for treatment persons who attempt suicide. Moreover, recognition of a right to suicide assistance could easily lead to the legalization of "homicide by consent." The Ninth Circuit views this possible development with complete equanimity. *Compassion in Dying*, 79 F.3d at 831-32.

Notwithstanding their disclaimers, the right respondents ask this Court to recognize could *not* be limited to mentally competent, terminally ill patients. This is apparent from respondents' reliance upon this Court's abortion jurisprudence and the extensive case law that has developed in support of the right to refuse medical treatment. If abortion jurisprudence is the source of a right to suicide, the States would be powerless to examine the reasons persons would want to kill themselves and then, based on that examination, permit some suicides (the "rational" ones) and forbid others (the irrational ones). *See Casey*, 505 U.S. at 879 ("[the] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability").

The case law recognizing a right to refuse treatment offers even less reason to believe that a right to suicide (or suicide assistance) could be contained. The right to refuse unwanted medical treatment, including life-sustaining medical treatment, may be exercised *by* persons who are not terminally ill and *for* persons who are not competent. *See* Edward R. Grant and Paul Benjamin Linton, *Relief or Reproach? Euthanasia Rights in the Wake of Measure 16*, 74 OREGON L. REV. 449, 459-61 & nn. 36-39 (1995) (listing cases). A right to assistance in commiting suicide, once established, would inevitably expand to include the incompetent and those who are not terminally ill, as the Ninth Circuit freely acknowledged.[26] *See generally* Grant and Linton, *Relief or Reproach?*, 74 OREGON L. REV. at 516-25 & nn. 293-328.

Only three years ago, the Supreme Court of Canada was asked to legalize the same practice of physician-assisted suicide that respondents urge upon this Court. *See Rodriguez v. British Columbia*, [1993] 3 S.C.R. 519. The Court refused to do so in an opinion that bears careful reading. The prohibition of assisted suicide, the Court stated, "is valid and desirable legislation which fulfills the government's objectives of preserving life and protecting the vulnerable." *Id.* at 590. A "blanket prohibition" of assisted suicide is neither arbitrary nor unfair in the sense of being "unrelated to the state's interest in protecting the vulnerable." *Id.* at 595.

> [The law against assisted suicide] has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This policy finds expression . . . in the provisions of our *Criminal Code* which prohibit

---

[26] *See Compassion in Dying*, 79 F.3d at 816: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 832 n. 120 ("we should make clear that a decision of a duly-appointed surrogate decision maker is for all legal purposes the decision of the patient himself").

> murder and other violent acts against others notwithstanding the consent of the victim, ...

Id. The Court declined to sanction assisted suicide, even for the terminally ill, because "the active participation by one individual in the death of another is intrinsically morally and legally wrong" and "there is no certainty that abuses can be prevented by anything less than a complete prohibition." *Id.* at 601. "Creating an exception for the terminally ill might . . . frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop." *Id.* The law against assisted suicide "may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide." *Id.* at 608.

To confirm the right of the States to preserve and protect human life, and to prevent the abuses that would arise if assisted suicide were legalized, *amici* ask the Court to uphold the New York and Washington statutes banning assisted suicide.

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request this Honorable Court to reverse the judgments in Cases 95-1858 and 96-110.

Respectfully submitted,

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November 7, 1996

APPENDIX

APPENDIX

List of *Amici* from the New York General Assembly

Senator Kenneth P. La Valle (Rep.-Conserv.-Ind.-Property Tax Cut) Chairman, Higher Education Committee	1st District
Senator Ceasar Trunzo (Rep.) Chairman, Civil Service & Pensions Committee	3rd District
Senator Owen Johnson (Rep.) Vice-President *Pro Tem*	4th District
Senator Kemp Hannon (Rep.) Chairman, Health Committee	6th District
Senator Dean G. Skelos (Rep.)	9th District
Senator Frank Padavan (Rep.) Chairman, Cities Committee	11th District
Senator George Onorato (Dem.) Secretary, Senator Minority Conference Ranking Minority Member, Veterans Committee	14th District
Senator Serphin R. Maltese (Rep.) Chairman, Elections Committee	15th District
Senator Seymour P. Lachman (Dem.)	22nd District
Senator John J. Marchi (Rep.) Chairman, Corporations, Authorities & Commissions Committee	24th District
Senator Olga A. Mendez (Dem.) Chairwoman, Senate Minority Conference Ranking Minority Member, Social Services Committee	28th District
Senator Larry Seabrook (Dem.)	33rd District
Senator Joseph R. Holland (Rep.) Chairman, Social Services Committee	38th District
Senator William J. Larkin, Jr. (Rep.) Chairman, Racing and Wagering Committee	39th District
Senator Hugh T. Farley (Rep.) Senate Majority Whip Chairman, Banks Committee	44th District
Senator John A. De Francisco (Rep.) Chairman, Tourism, Recreation & Sports Development Committee	49th District
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Senator Dale M. Volker (Rep.) Chairman, Codes Committee	59th District
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Assemblyman John J. Flanagan (Rep.-Conserv.)	9th District
Assemblyman James D. Conte (Rep.) Ranking Minority Member, Governmental Employees Committee	10th District
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Assemblyman Jules Polonetsky (Dem.)	46th District
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Assemblywoman Aurelia Greene (Dem.) Chairwoman, Banks Committee	77th District
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Assemblyman James N. Tedisco (Rep.)	103rd District
Assemblyman John J. McEneny (Dem.)	104th District
Assemblyman Robert G. Prentiss (Rep.) Ranking Minority Member, Veterans Affairs Committee	107th District
Assemblyman David R. Townsend, Jr. (Rep.-Conserv.) Ranking Minority Member, Labor Committee	115th District

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Assemblyman Daniel J. Fressenden (Rep.) **Ranking Minority Member,** Environmental Conservation Committee	125th District
Assemblyman Joseph T. Pillittere (Dem.) Chairman, Tourism, Arts & Sports Development Committee	138th District
Assemblyman David E. Seaman (Rep.)	139th District
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Assemblyman Richard J. Keane (Dem.)	145th District
Assemblyperson Sandra Lee Wirth (Rep.)	148th District

List of *Amici* from the Washington General Assembly

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Senator James E. West (Rep.)	6th District
Rep. Assistant Floor Leader	
Senator Alex Duccio (Rep.)	14th District
Rep. Deputy Floor Leader	
Senator Joseph P. Zarelli (Rep.)	18th District
Senator Daniel P. Swecker (Rep.)	20th District
Senator Jim Hargrove (Dem.)	24th District
Senator Bob Oke (Rep.)	26th District
Senator Pam Roach (Rep.)	31st District
Senator Gary Strannigan (Rep.)	38th District
Senator Emilio Cantu (Rep.)	41st District
Senator Jeanine Long (Rep.)	44th District
Representative Mike Sherstad (Rep.)	1st District
Representative Tom Campbell (Rep.)	2nd District
Representative Scott Smith (Rep.)	2nd District
Representative Duane Sommers (Rep.)	6th District
Representative Cathy McMorris (Rep.)	7th District
Representative Larry Sheahan (Rep.)	9th District
Chairman, House Law & Justice Committee	
Representative Mark G. Schoesler (Rep.)	9th District
Assistant Majority Floor Leader	
Representative Barney Beeksma (Rep.)	10th District
Representative Joyce Mulliken (Rep.)	13th District
Representative Jim Honeyford (Rep.)	15th District
Representative Steve Hargrove (Rep.)	23rd District
Representative Jim Buck (Rep.)	24th District
Representative Grant O. Pelesky (Rep.)	25th District
Representative Sarah M. Casada (Rep.)	25th District
Representative Lois McMahan (Rep.)	26th District
Assistant Majority Whip	
Representative Gigi Talcott (Rep.)	28th District
Majority Whip	
Representative Mike Carrell (Rep.)	28th District
Representative Tim Hickel (Rep.)	30th District
Representative Les Thomas (Rep.)	31st District
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Republican Caucus Vice Chair	
Representative Kathy Lambert (Rep.)	45th District
Representative Bill Backlund (Rep.)	45th District

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No. 95-1858
No. 96-110

IN THE

SUPREME COURT OF THE UNITED STATES

October Term,1996

DENNIS C. VACCO, Attorney General
of the State of New York,
GEORGE PATAKI, Governor of the State of New York
ROBERT M. MORENTHAU, District Attorney
of New York County

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D.,
and HOWARD A. GROSSMAN, M.D.

Respondents.

On Writ Of Certiorari To The U.S. Court Of Appeals For The Second Circuit

STATE OF WASHINGTON, AND CHRISTINE GREGOIRE
Attorney General of the State of Washington

Petitioners,

v.

HAROLD GLUCKSBERG, MD., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D. and PETER SHALIT, M.D., Ph.D.

Respondents

On Writ Of Certiorari To The U.S. Court Of Appeals For The Ninth Circuit

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QUESTION PRESENTED

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STATEMENT OF INTEREST

The International Anti-Euthanasia Task Force (IAETF) is the trade name of the Family Living Council, a non-profit corporation formed in 1976 to provide education in matters related to family life, health and related matters. The IAETF, with networkers throughout the world, addresses the medical-ethical issues of death and dying, health care delivery, the rights of the terminally ill, the chronically ill, the elderly, persons with disabilities and their families. Involvement of the IAETF in such matters includes education, advocacy, consultation, legislative analysis and networking. The IAETF is a major resource for individuals and groups seeking information about the rights of medically vulnerable individuals and their families.

This *amicus curiae* brief has been filed with consent of the parties. Letters of consent were filed with this brief with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

The matter at bench is one of the most important constitutional challenges ever to face this Court. At stake is the determination of the very organizational purpose for which our society, under law, exists.

This Court will decide whether the state's foundational role as protector of the lives of all of its citizens is consistent with existing constitutional principle and the law, or whether this traditional state responsibility will be superseded and replaced by new and radical constitutional notions which prohibit states from protecting their citizens and, further, force states to countenance and facilitate the deliberate ending of human lives under the guise of compassion, elimination of suffering, and exercise of individual rights.

The current question before the Court is not whether dying patients have the right to end their suffering, as Respondents argue. (Certainly, the ending of suffering is a laudable goal and, if that were the real issue, there would be no controversy.) Rather, the issue before this Court is whether states

have the right to protect weak and vulnerable individuals as well as the greater societal good by prohibiting assisted suicide.

Strong emotional arguments are made by Respondents who seek to have this Court decide that existing state laws which proscribe assisted suicide are unconstitutional. Proponents of this radical theory of constitutional jurisprudence claim that the state has little or no legitimate interest in prohibiting assisted suicide because the assisted suicide of patients would permit them to determine "the time and manner of one's own death"[1] and would be used as " a treatment of last resort,"[2] to take place only after people have exhausted all treatment and comfort care possibilities.

As this brief will demonstrate, such conclusions and arguments are facile, designed as a veneer to deflect the Court's attention from the context in which legalized assisted suicide would be practiced. This brief argues that assisted suicide, as it would take place in the "real world," demonstrates both the rational and vital state interests promoted by state laws which currently outlaw assisted suicide.

The "last resort" claim is based upon the false premise that virtually every American citizen or resident has access to wanted medical treatment and necessary health care. Further, it mistakenly assumes that all necessary time and health care resources would be at the disposal of each suicidal patient prior to any implementation of physician facilitated death.

The reality of the United States health care delivery system belies these soothing assurances. An increasing number of people are experiencing great difficulty in obtaining necessary medical services, in part because of the ongoing transition from "fee for service" medicine to "managed care." In such a milieu, this brief argues, assisted suicide would be especially dangerous.

Managed care systems often have financial incentives which impose conflicts of interest between patients and their

1. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996).

2. F. Miller, T. Quill, et al, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119,120 ((1994).

own doctors. These conflicts create the potential for denial of wanted and needed medical care based on pecuniary, rather than medical, considerations. In turn, the suffering caused by denied or delayed care can create a desire for assisted suicide.

The "medical practice" of assisted suicide would not be implemented in a vacuum. There is nothing to indicate that a judicially created transformation of assisted suicide from a crime into a legitimate form of medical treatment would cause the health care delivery system to become more responsible to patient needs, nor would it afford a compassionate means for patients to have their suffering alleviated. If anything, the availability of assisted suicide would likely result in a decreased amount of time and attention given to treating and alleviating significant medical problems, such as pain, particularly when assisted suicide would be far less time-consuming and less costly than interventions which alleviate pain while not taking the patient's life. This latter point is especially pertinent in a health care system dominated by managed care.

It is within the context of the growing managed care system of health delivery and the growing prominence and influence of for-profit health maintenance organizations (HMOs) that the far reaching implications of striking laws which prohibit assisted suicide must be considered. Considering the financial implications of legalizing assisted suicide as it relates to proper patient care, a state not only has the right but the positive responsibility, to protect its citizens by prohibiting assisted suicide.

I. IN STRIKING DOWN STATE LAWS PROHIBITING ASSISTED SUICIDE, THE SECOND AND NINTH CIRCUITS FAILED TO ADEQUATELY CONSIDER THE ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO ACCEPT ASSISTED SUICIDE.

The Second Circuit Court in *Quill v. Vacco*[3] erroneously disregarded the importance of the significant economic and psychological pressure that would be placed on individuals if states were barred from prohibiting assisted suicide. In strik-

3. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

ing down New York's laws against assisted suicide, the Second Circuit nonchalantly suggested that any such pressures could be alleviated by state formulated guidelines: "In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures."[4] Not only did this suggestion totally ignore the carefully drafted report of the New York State Task Force on Life and the Law,[5] which clearly outlined and documented the peril in which citizens would be placed if assisted suicide were permitted, even under guidelines intended to be protected, it also failed to take note of the reality of the current state of the health care delivery system.

Likewise, the Ninth Circuit, in concluding that state laws against assisted suicide are unconstitutional, paid little attention to this reality.

After a cursory acknowledgment that economic factors and lack of adequate health care may well influence an individual's decision to die by assisted suicide, the Ninth Circuit fastidiously decided to "stand aside from that battle."[6] The Court implied that, if assisted suicide were not available to those who are already injured by the lack of access to adequate health care, they would be further harmed: "On the other hand we are certainly not obligated to pile injury upon injury. . . ."[7]

In fact, by removing the states' rights to protect vulnerable citizens from the considerable economic pressure to die and get out of the way, the Second and Ninth Circuits did pile injury upon injury. In concluding that states should not be able to prohibit assisted suicide, both courts sent a bold message that access to death-producing medical intervention is a constitutional right, but access to life saving or life enhancing medical intervention is not.

4. Id, at 730.

5. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994).

6. Supra note 1, at 826.

7. Id.

II. IN DETERMINING WHETHER STATES HAVE BOTH A VITAL AND RATIONAL INTEREST IN PROHIBITING ASSISTED SUICIDE, THIS COURT MUST CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIED OUT.

A. Managed Care Has Changed the Very Basis upon which Health Care Is Provided.

In an effort to control unnecessary medical costs and improve the efficiency of health care, a transition of monumental import is currently taking place in the health care system. This transition is from a traditional "fee-for-service" system to a "managed care" system of health care delivery.

Under the fee-for-service system, health providers were paid for each service performed. This sometimes led to patients' being overtreated and subjected to interventions that were futile. In the fee-for-service system, health providers had a financial incentive to exhaust all treatment possibilities or provide unnecessary care since the more treatment that was given, the greater was a provider's income.

Managed care operates in a manner that is almost a reverse of the fee-for-service system. Under managed care, health providers are encouraged by a myriad of incentives and disincentives to control costs by *limiting* treatment and care. Health care professionals now find that their incomes, in large part, depend upon providing fewer, not more, services.

While there is nothing inherently wrong with the concept of managed care, nor with the attempt to appropriately control health care costs, managed care, as it presently operates, has caused enormous problems: "Prodded by large companies fed up with rising medical costs, the new medicine's entrepreneurs have turned health care into a corporate battlefield increasingly governed by the promise of stock market wealth, incentives that reward minimal care and a brand of aggressive competition alien to front-line doctors. . . ."[8]

8. Larson, *The Soul of an HMO*, Time, Jan. 22, 1996, at 45.

The usual and traditional presumptions about health care financing and delivery have been turned inside out, and its effects are being felt by millions of people.

In 1995 up to 130 million people were in some type of managed care program.[9] Among American workers who are covered by health insurance, seventy-one percent are in managed care programs[10] and, according to the Health Care Financing Administration's Office of Managed Care, eighty thousand Medicare beneficiaries are being transferred each month from traditional fee-for-service health plans into managed care programs.[11]

The number of physicians affected by the growth of managed care is also increasing rapidly. Whereas physicians used to be self-employed and, thus, were ultimately in charge of how much time they spent with patients and how much care they wished to provide for a certain fee, more and more doctors are now becoming employees who are subject to control by managed care organizations. According to the American Medical Association, only slightly over half of doctors remained self-employed by 1995.

Indicative of the new way in which medicine is practiced is the terminology now used in conjunction with medical care. Provider-consumer business terminology has largely replaced references to what was formerly called the physician-patient relationship. Such business oriented designations have caused grave concern among physicians.[12]

The agreements used in that provider-consumer relationship have undergone such a significant transformation that the meanings of commonly used words and phrases may now mean something far different to the consumer than they do to

9. D. Blumenthal and S. Thier, *Managed Care and Medical Education*, 276 J.A.M.A. 725 (1996).

10. Myerson, *Executives Are Cradled while Medicaid Benefits Are Cut for Rank and File*, N.Y.Times, March 17, 1996, at 1, 13.

11. Johnsson, *Managed Care Fraud*, Am. Med. News, May 20, 1996, at 3, 26.

12. See, e.g., J. Olivero, *Why "Providers" Instead of Physicians?*, 156 Arch. Inter. Med. 2148 (1996).

the provider.[13] Additionally, this consumer-provider construct bears striking similarity to one which is contractual in nature. In a contractual relationship, however, there is generally some type of parity as it relates to information. That parity is lacking in the medical realm under managed care. It is the provider who has virtually all of the information. It is the provider who may withhold information on the basis of possible benefit or potential harm to the provider. It is the consumer who often does not have adequate information, because the provider has withheld it.

This presents a clear conflict for physicians and increases the possibility of grave harm to patients, a matter clearly relevant to the matters before the Court. If states were prohibited from banning assisted suicide, patients who were denied full access to information about the availability of treatment could be led to believe that assisted suicide was their only remaining option.

B. Managed Care Programs Use a System of Financial Incentives and Disincentives which Impose Conflicts of Interest between Patients and Their Doctors.

Under the doctrine of informed consent physicians have a common law duty to provide patients with all information that is material to that patient's treatment decisions. This duty encompasses informing patients about all reasonable treatment alternatives, and the risks and benefits of each, regardless of cost.[14]

Additionally, a patient has the right to be told about financial incentives that may exist to induce physicians to manipulate the range of options offered to the patient. The physician has an obligation to "disclose personal interests

13. See, e.g., R. Marker and W. Smith, *The Art of Verbal Engineering*, 35 Duq. L. Rev. 81 (1996).

14. *Cobbs v. Grant*, 8 Cal. 3d 229 (1972).

unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."[15]

Despite the existence of clear requirements for such disclosure, managed care programs have created barriers between physicians and patients which threaten a patient's right to receive complete and accurate information and which compromise the professional responsibility of physicians. These barriers arise from a combination of factors: a method for health services payment referred to as "capitation," a combination of financial incentives and disincentives, and the existence of what are called "gag rules" in managed care contracts.

These approaches, used by managed care organizations, hold down costs by controlling physicians' fees and limiting patients' access to services. They could be accurately described as a "carrot and stick" method which compensates physicians in direct proportion to how little they do for patients.

Under the "capitation" approach, the managed care organization pays a flat fee per patient per month to a physician or group of physicians. For example, under one managed care plan, physicians receive $8.43 each month for every male patient between the ages of twenty-five and forty-four and $10.09 per month for each female patient between the ages of twenty and twenty-four.[16]

15. *Moore v. Regents of the University of California*, 793 P. 2d 479, 271 Cal. Repr. 146 (1990).

16. *Compromising Health Care*, Wash. Post, June 16, 1996, at C8. At the same time that doctors and other health professionals are being pushed to see more and more patients for less and less pay, and as patients are often being denied needed treatment, it is estimated that profits of twenty to thirty percent are going into the pockets of investors. In 1995, the total compensation package of the typical health care corporate CEO was close to $2.9 million. Auerbach, *As the Marketplace Changes, Consumers Are Caught in the Middle*, Wash. Post, June 25, 1996, at Z12. Several earned between $8.8 and $15.5 million per year. Freudenheim, *Health Chief's Big Paychecks for Chopping Costs*, N. Y. Times, Apr. 11, 1995. That does not take into account stock dividends paid to investors.

In return for the monthly fee per patient, the physician is to provide all medical services (subject to the terms of the managed care contract) for each covered patient. These services generally include primary care, specialty care, hospitalization, prescriptions, and a broad range of other health care services. If, during any given month, the actual cost of care for the covered patients is lower than that of the fees paid, the doctor retains the excess. If, however, the actual cost of care exceeds the fees, the health provider loses money. The possibility of losing money by providing care can be a powerful incentive to deny even needed care.[17]

Another cost control method, often coupled with capitation, depends upon what is referred to as a "withhold" in which the managed care organization withholds a percentage of the per patient fee that would ordinarily be paid to the physician. At the end of a certain period of time, the managed care program reviews the physician's practice and determines whether the physician should receive any of the withheld fees. If the managed care program determines that the physician is spending too much time per patient or that he or she is ordering too many diagnostic tests or providing too much treatment, the managed care organization retains the withheld fee. Amounts withheld in this manner vary from a low of eleven percent (withholds of less than eleven percent have been found ineffective as an incentive for physician's to limit services and referrals) to more than thirty percent.[18] Even when income is not withheld, some managed care organizations place a lien on future earnings or reduce the capitation fee as a means of penalizing a physician's failure to meet the fiscal expectations and requirements of the managed care program.[19]

According to data compiled in 1995 by the American Medical Association, one-third of doctors have capitated com-

17. See generally: Freudenheim, *Health Care in the Era of Capitalism*, N.Y.Times, Sept. 4, 1996, at 6E; and T. Bodenheimer and K. Grumback, *Capitation or Decapitation*, 276 J.A.M.A. 1025 (1996).

18. E. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, 35 (Georgetown University Press, 1995).

19. Id.

mercial contracts, and forty-eight percent are subject to some method of fee withhold. For doctors who have such contracts with manage care programs, nineteen percent of their income is attributed to capitation accounts.[20]

The wedge that such financial incentives and disincentives places between patients and doctors is intensified by another provision, referred to as a "gag rule," that is contained in many contracts between managed care organizations and physicians.

C. Managed Care Programs Have Created Barriers between Physicians and Patients which Violate Patients' Rights to Receive Complete and Accurate Information about Their Health Care.

Doctors who sign managed care contracts that have gag rules are prevented from providing often essential information to patients. Some gag clauses forbid a doctor from telling a patient about treatment options until the plan approves the specific treatment for that patient. Other programs prevent a doctor from telling a patient that a beneficial treatment that is not covered by the program is available elsewhere.

Under the gag clause provisions doctors say they cannot talk freely to patients about either their treatment options or about the particular managed care program's payment policies. They are even forbidden to tell patients that doctors who save money by withholding care get financial bonuses.[21]

Gag clauses also prohibit informing patients about outside "gatekeepers."

For example, one managed care organization sent a notice to physicians under contract with its program stating, "Do not discuss proposed treatment with [the managed care program's] members prior to receiving authorization" and further directed doctors to avoid discussing the procedures that must be followed to obtain such authorization[22]

20. Johnsson, *Trial Focus: Public Unease with Physician Incentives*, Am. Med. News, Aug. 12, 1996, at 1, 34.

21. Pear, *Doctors Say H.M.O.'s Limit What They Can Tell Patients*, N.Y. Times, Dec. 21, 1995, at A1.

In many managed care programs, it is the primary care physician who serves as the gatekeeper. Physician gatekeepers may come under considerable pressure to deny access to services as evidenced by a warning, given by one managed care organization to physician gatekeepers in its program, stating that the physicians' contracts would be terminated if they approved too many specialist referrals. [23]

Other programs rely on outside gatekeepers (who may be physicians, nurses or persons who are not trained in medicine). Outside gatekeepers may be located in a different city or state and have no personal contact with the patient or the patient's primary care physician. This type of gatekeeper or reviewer is often compensated on the basis of cost saving for the managed care organization.

The role of an outside reviewer was described by Dr. Linda Peeno when she testified before the House Commerce Health Subcommittee. Dr. Peeno, who had served as a medical reviewer for a managed care program, said she saved her employer money by denying treatment. She explained that, in one such case, her decision led to a man's death but, rather than being held accountable, she was financially rewarded. She earned an annual six-figure income by using her medical expertise to bring financial gains to the organization. "According to the managed care industry, it is not an ethical issue to sacrifice a human being for a 'savings,'" she said.[24]

D. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resist Attempts to Assure Patients' Rights.

Until very recently, health institutions, both public and private, were overwhelmingly non-profit endeavors. However,

22. Id.

23. Reuters Health News Service, *HMOs Respond to Member Complaints*, Aug. 20, 1996.

24. Gianelli, *Congress Considers Ban on Managed Care "Gag" Clauses*, Am. Med. News, June 19, 1995, at. 5, col. 1.

for-profit organizations are becoming the rule, rather than the exception, so that more than seventy percent of all HMOs are now for-profit corporations. With this change has come a shift in focus. Within the non-profit realm, any excess money is earmarked to improve services, access and care for the served population. In the for-profit sphere, money saved by limiting services benefits corporate shareholders. Meeting profit projections supplants meeting patient needs and is the driving force in the for-profit arena.

It would seem reasonable to assume that if patients demand types of care that may increase costs, managed care programs would respond since pleasing the customer has always been considered good business practice. The program could then pass on the costs to the consumer by raising premiums. However, this assumption misses a crucial point. In most cases, employers, not individual subscribers, pay the premiums, so they are the customers who must be pleased. Further, it is the employer, seeking to keep expenditures for employee benefits down, who will opt for a program that keeps rates down.

In 1995, a broad coalition of patient and provider groups drafted a set of standards on the rights of patients, including the right to information about provider incentives or restrictions that might influence practice patterns. Managed care organizations refused to sign on. Although the principles were endorsed by over one hundred groups including the American Medical Association, American Cancer Society, American Association of Retired Persons, and the Joint Commission on Accreditation of Health Care Organizations, a managed care representative explained that the principles seemed to be "too close to the operational issues" of managed care.[25] A subsequent attempt to adopt government regulations restricting managed care organizations' practice of incentives and gag rules was successfully resisted by managed care programs. The

25. Page, *Managed Care Firms Balk at Patient Rights Agreement*, Am. Med. News, Dec. 4, 1995, at 3, 23.

managed care industry claimed that such practices are important in "a fast-moving, intensely competitive industry."[26]

With their sites firmly on profit margins and beating the competition, it seems reasonable to predict that managed care corporations would be more than willing to reimburse for inexpensive assisted suicide services that would eliminate the need for some costlier services.

E. Denial of Emergency Care which Often Occurs as a Result of Managed Care Can Create the Very Conditions that May Lead to Assisted Suicide.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide "a standard medical screening evaluation"[27] to anyone who goes to an emergency room requesting care. In addition, the hospital must give any treatment that is necessary to stabilize the patient's condition, making use of all necessary and routinely available facilities of the hospital to reach a diagnosis that rules out the presence of a legally defined emergency medical condition.[28]

Emergency physicians are well aware that any delay in emergency care while seeking to obtain authorization for payment may be detrimental not only for the patient but may result in liability for the hospital.[29] However, managed care organizations and clinics run by health maintenance organizations are not within the scope of these requirements since "the plain wording of the statute makes reference only to 'hospitals' and shows legislative intent to provide emergency medical treatment by hospitals to all individuals."[30] Managed care organizations escape responsibility under EMTALA because they are only authorizing payment, not treatment.

26. Pear, *U.S. Shelves Plan to Limit Rewards to HMO Doctors*, N.Y.Times, July 8, 1996.

27. 42 USC 1395 dd (a).

28. 42 USC 1395 dd (b).

29. 42 USC 1395 dd (h). See, e.g., *Griffith v. Mount Carmel Hospital*, No. 92-1141-MLB, (D. Kan. Aug. 23, 1993).

30. *Dearmas v. Av-Med Inc.*, 814 F. Supp. 1103, 1108 (S.D. Fla. 1993).

Although, technically speaking, the managed care organizations cannot deny authorization to receive emergency treatment,[31] managed care policies do operate to block emergency room care by denying payment if pre-authorization is not obtained. Thus, a clear conflict exists between federally mandated medical screening examinations and the pre-authorization processes that are required by most managed care organizations. "Managed care requirements that patients be pre-authorized for emergency department visits or admissions are totally inconsistent with and unregulated by EMTALA."[32]

Emergencies are, by definition, unexpected and difficult to manage. Obtaining pre-authorization in an emergency situation can result in loss of time and loss of life. Nonetheless, managed care programs continue to require pre-authorization. As one members' handbook stated (in fine print), "Failure to contact the primary care physician prior to emergency treatment may result in denial of payment."[33]

According to Dr. Charlotte S. Yeh, chief of emergency medicine at the New England Medical Center in Boston, "In some ways, it's less frustrating for us to take care of homeless people than HMO members. At least we can do what we think is right for them, as opposed to trying to convince an HMO over the phone of what's the right thing to do."[34]

Such inconsistencies can place patients at risk and may force emergency room physicians to choose between providing necessary medical care or facing loss of hospital privileges for providing care that may not be reimbursed. In a survey of 1,047 board-certified emergency physicians, 18.6% said "they

31. "Managed healthcare plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will and will not pay for, and regardless of whether a hospital is to be reimbursed for the treatment, it is obligated to provide the services specified in EMTALA." HCFA's Rules and Regulations, 59 *Fed. Reg.* 32,116 (1994).

32. S. Frew, *Managed Care, in Patient Transfers: How to Comply with the Law*, (American Academy of Emergency Physicians, Second Edition, 1995)

33. Pear, *HMO's Refusing Emergency Claims, Hospitals Assert*, N.Y.Times, July 9, 1995, at 1,12.

34. Id.

had been threatened or lost hospital privileges because they voiced concerns about quality of care."[35]

At a time when managed care cost containment provisions make even emergency care difficult to obtain, it would be incredibly naive to assume that the same managed care programs would authorize access to all medical options, some of which may be expensive, before approving the cost effective treatment of assisted suicide.

Indeed, managed care programs have consistently resisted providing services which, under fee-for-service, were previously included within even the most basic type of health care coverage. Even after there was tremendous public outcry about so-called "drive through deliveries" – in which new mothers and their infants were sent home from the hospital within hours of birth – many managed care programs maintained their refusal to pay for more than a day of hospitalization. It took federal legislation to require that new mothers and their infants could receive a minimum hospital stay of 48 hours after birth.[36]

It seems reasonable to believe that managed care programs which had to be forced to allow new mothers and infants to receive an additional 24 hours of hospitalization, may be less than willing to permit months of palliative care or great amounts of long term therapy for chronic conditions. This would be particularly true if the same managed care programs could authorize the provision of a lethal prescription as a quick and inexpensive means to "treat" the same condition.

In fact, most managed care organizations fail to provide services which address anything other than short term cost effectiveness.

35. *American Academy of Emergency Medicine Survey Preliminary Report*, Emergency Med. News, August 1995.

36. Veterans Administration.-HUD Appropriations Act of FY 1997, Pub. L. No.104-204, 110 Stat.2874, Title VI, Sec. 601 (Sept. 26,1996).

F. Managed Care Programs Often Operate in a Manner that Indicates a Quest for Only Short Term Effectiveness and Maximum Cost Containment

For medical conditions, like appendicitis or minor infections that can be addressed in the short term, managed care programs do relatively well. Problematic, however, is the care received by people who have conditions that require long term care. Thus, a relatively healthy person who enters into a managed care program will generally be satisfied with the program as long as his or her health remains good overall. If, as often happens, a person develops a condition, like multiple sclerosis, that requires on-going care, managed care often falls short of expectations.[37]

Additionally, while all managed care programs emphasize preventative care, not all have programs to prevent complications that can result from chronic disease. The way in which managed care deals with diabetes is an illustration of the quest for short term cost effectiveness. Fewer that one-half of HMOs have implemented programs to manage diabetes[38] even though more than 14 million Americans are known to have diabetes,[39] which can cause blindness, kidney failure, nerve damage and is the fourth leading cause of death in the United States.[40]

Regimens that could result in greatly reduced costs in terms of patients' lives and health care resources have sometimes been ignored in the interest of immediate monetary saving. When the National Institute of Health (NIH) supported a study on diabetes that showed that good control would reduce the complications of diabetes, managed care organizations indicated a marked lack of interest in the program. According to Dr. Judith Vaitukaitis, director of the National Center for

37. Rosenthal, *Patients Say N. Y. HMOs Don't Deal Well with Complex Illnesses*, N.Y.Times, July 15, 1996, at A19.

38. Reuters Health News Service, *HMO Enrollment Surpasses 59 Million in U.S.*, Oct. 23, 1996.

39. Blakeslee, *Program to Cut Risks of Diabetes Surprisingly Fails to Lure Patients*, N.Y.Times, Feb. 28, 1994, at A1,5.

40. *New Diabetes Treatment May Block Worst Effects*, San Francisco Chron., June 14, 1993, at A3.

Research Resources at NIH, this stance on the part of managed care programs was due to the fact that the managed care organizations did not want to spend the extra time and resources that good control would require. She explained that "the benefit of reduced complications is not seen for years ahead and they [managed care organizations] don't see the benefit in reduced costs because of the rapid turnover of their members."[41]

This emphasis on quick profits has also been described by Dr. George Lundberg, editor-in-chief of the *Journal of the American Medical Association*, who stated, "Getting managed care companies to think in terms of the long term is starry-eyed. Profit is to be made here. The managed care companies are not interested in the long term."[42]

It would seem logical for managed care organizations to promote long term preventative care since this would result in future savings. However, according to health care consultant Theodore J. Weinberg, individuals change health care programs about every three or four years.[43] The advantages of long term preventative measures may not show up for ten years or more and, by that time, a person may be in another managed care program. Consequently, competitive managed care programs are unlikely to invest in outcomes that would not pay off within a short period since the investment in a prevention program paid for by one managed care organization may result in better health (and thus lower expenditures) for enrollees in a competitor's program.

With this short sighted approach to health care, the long term consequence could be greater numbers of debilitated individuals who would create additional strain on the health delivery system. This, in turn, could spur greater incentives for managed care programs to promote assisted suicide as what one euthanasia advocate has called "a new age form of hospice care."[44]

41. C. Marwick, *Effect of Managed Care Felt in Every Medical Field*, 276 J.A.M.A. 768 (1996).

42. Id.

43. Id.

44. *Kevorkian Takes Stand in Own Defense*, N.Y. Times, Apr. 28, 1994,

G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Exacerbated by the Practices of Managed Care Programs.

A 1996 Gallup poll, conducted for the National Hospice Organization, regarding public attitudes about assisted suicide found that, among their greatest fears about death, people fear most the prospects of dependence, pain and loss of dignity.[45] In many ways, the current practices in managed care programs operate in a manner that turns these fears into reality.

It is often chronically ill patients, particularly those who are elderly or poor, who are hardest hit by the cost containment aspects of managed care. Within HMO plans, such patients fare poorly in comparison to similar patients in fee-for-service plans.[46] Their plight may become even more pronounced in the future since these patients "account for a disproportionate share of health care expenditures and are therefore prime targets of cost containment." [47]

It is well known tnat chronic conditions can often be controlled or, at least, their progression can be slowed down if appropriate and necessary care is provided. The lack of emphasis placed on chronic care by managed care organizations can actually lead to patients' becoming dependent sooner than they would have been if appropriate care had been provided. Thus, managed care's lack of attention to chronic conditions may serve to heighten dependence which a great number of people fear and could actually lead to a greater number of people considering assisted suicide.

NOTES *(Continued)*

at A8. Dr. Stanley Levy, an internal medicine physician who specializes in geriatrics, called the activities of Jack Kevorkian "new age hospice care" while testifying for the defense during Kevorkian's trial in the death of Thomas Hyde, who died of carbon monoxide poisoning on August 4, 1993.

45. National Hospice Organization, Press Release, Oct. 3, 1996, at 2.

46. J. Ware, M. Bayliss, W. Rogers, M. Kosinski, A. Tarlov, *Difference in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 J.A.M.A. 1039 (1996).

47. Id., at 1040.

The fear of unremitting pain which causes great anxiety for patients and which some have said could lead them to seek assisted suicide is heightened due to the inaccessibility of pain control for many people. It is the lack of access, not an absence of such interventions, that creates this tragic situation. Patients are often forced to endure pain because third party payers refuse to reimburse for its treatment. In effect, "by rationing pain management on a financial basis, patients are being forced to consider death as their only option."[48]

Navigating the murky waters of services not covered, services not approved and the complex methods of co-payments is particularly difficult for patients who are in pain. They have precious little energy to deal with a system that seems to block their access to necessary pain relief at every turn.

This denial of needed pain control is most pronounced within certain categories of patients. In 1994, the State of California's "Summit on Effective Pain Management"[49] found that third party payers often restrict payment for pain-related services.[50] It further found that pain is more likely to be undertreated if the patient is a member of a minority, female, elderly, or a child.[51]

Among these groups who are undertreated, the problem of pain relief is especially difficult for the elderly. Until recently, management of pain in elderly patients was largely ignored, although findings indicate that the prevalence of pain in the elderly is known to be twice that of younger people and can be as high as eighty-five percent in older people living in

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48. K. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain and Symptom Mgmt. 289, 292 (1991).

49. In March 1994, the State of California sponsored a "Summit on Effective Pain Management" at which more than 120 health care practitioners, professional and public educators, representatives of professional schools and associations, and health care consumers met to identify and recommend solutions to legal, professional, and educational barriers to effective pain management.

50. State of California, *Report on "Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing,"* 5 (1994).

51. Id.

long-term care settings,[52] even though individualized pain management plans for older people can be highly effective.[53] The problem in a managed care context is that individualized plans are time consuming.

Nurses, in particular, have been important in providing the personalized attention needed for effective pain management plans. The nurse's role has been particularly important since it has been the nurse who has previously been able to spend the time to communicate carefully with the elderly patient so that pain control needs can be accurately assessed. Now, however, in attempts to reduce costs in the realm of managed care, many hospitals and other health facilities are cutting back on their nursing staffs and patients are finding that not only doctors, but nurses, no longer have time for them.

According to Howard Berliner, professor of health policy at the New School for Social Research, "Hospitals are under pressure from managed care to reduce costs, and they are looking at nurses as their highest-cost line item."[54] In many cases, nurses are being replaced with unlicensed aids who have neither the training nor skill required to serve as effective patient advocates.

The failure to allocate the necessary time and resources to giving adequate pain management creates the untenable situation, so greatly and rightfully feared by many people. This could well lead a patient to believe erroneously that "nothing can be done" to alleviate suffering and, in turn, this could result in a patient's choosing assisted suicide as the only available means to escape pain.

Patient concerns about loss of dignity are also heightened by the cost containment policies and requirements of managed care programs. It is difficult for patients to feel valued and

52. B. Ferrell, *Pain Management in Elderly People*, 39 J. Am. Geriatr. Soc. 64 (1991).

53. T. Fulmer, L. Mion, M. Bottrell *et al.*, *Pain Management Protocol: Inappropriate Pain Management Leaves Both the Elder and the Nurse Feeling Unfulfilled and Unhappy with the Care*, 17 Geriatr. Nurs. 222 (1996).

54. Rosenthal, *New York Hospitals Cut Costs by Laying Off Nurses*, N.Y.Times, Aug. 19, 1996.

cared for when physicians are compelled to treat them as though they were assembly line products being processed in an allotted number of minutes. This production line mentality was described by Dr. Leonard Laster, distinguished professor of medicine and health policy at the University of Massachusetts Medical Center in Worcester: "Business managers working in the interests of cost-cutting now tell doctors how much time to spend with a patient, and many allow only ten minutes for a returning patient and no more than twenty minutes for a new patient. How can anyone perform even a passable evaluation in twenty minutes on an elderly patient with a massive written clinical record. . . .?"[55]

Mandated time restrictions are not the only thing that can leave patients feeling demeaned and unimportant. Sometimes the greatest assaults on one's sense of self-worth emanate from small indignities. When one of the nation's largest managed care companies experienced losses in 1995, it instituted cost cutting measures which included the refusal to provide gowns for gynecological exam patients. Patients were told to disrobe and then, instead of being provided with a gown, they were given a small square of paper on which they were to sit while awaiting the examination.[56]

It stretches credulity to think that managed care programs — which fail to reimburse for adequate pain control, control exam times down to the minute, and deny a patient even a simple gown with which to cover herself — would allot large sums of money for comprehensive services so that assisted suicide would be used only as a last resort.

It could be assumed that, if patients are faced with demeaning and life threatening conditions such as have been described, they need only avail themselves of the appeal or complaint procedures that are in place in large corporations, including large health care corporations. However, the process of appealing a managed care program's decision is often time-consuming, costly and beyond the ability of many patients

55. Laster, *Managed Care Translates to "Let the Patient Beware,"* Am. Med. News, Feb. 19, 1996, at 18.

56. Auerbach, supra note 16.

who are already using every ounce of energy and every financial resource to exist on a daily basis. Meanwhile, as the quest for administrative remedies drags on, the patient's agony remains unrelieved.

H. The Appeals Process under Managed Care Is Often So Complex that Patients Could Consider Assisted Suicide to Be Their Only Recourse.

When essential treatment is denied, the appeals procedure under managed care is often so complex and time consuming that the accompanying delays can cause a patient grave harm. Additionally, personnel investigating the appeal may not have expertise in assessing the actual medical condition or its appropriate treatment. One such case involved a child with an extremely rare kidney tumor that is fatal if not treated but has a ninety-seven percent cure rate with prompt surgery. The child's primary care physician sought permission from the group plan to refer the child to an out-of-group specialist, since the group itself had no one with the needed expertise in treating the child's condition. The group's acting medical director, an ophthalmologist (eye specialist), refused to authorize the referral, saying that an in-group physician should perform the surgery. When the child's parents appealed, the appeal procedure was handled by a nurse who also denied the referral.

This left the family with two options: Have the surgery performed by a surgeon who was unqualified for it or personally bear the cost of an experienced medical team outside the group. Her parents opted for the latter, and the child's condition was cured. However, the managed care group not only refused to pay for the surgery but also denied any reimbursement for the accompanying hospital costs, even though these costs were identical to those that would have been incurred if an in-group physician had performed the surgery.

It took close to four years but, in October of 1996, the managed care program was fined by the California Department of Corporations for failing to provide the child "as well as all member patients with all medically necessary physician

services." It was also found that the managed care program had failed to demonstrate that its refusal to refer the child to a qualified surgeon was unhindered by fiscal and administrative considerations.[57]

Unfortunately, many people who are denied care, give up. They have neither the money to obtain care outside their managed care program nor the inclination to embark on court challenges. The outcome for such individuals could mean that a potentially fatal, yet curable, condition is allowed to progress. If assisted suicide is permitted, such individuals may well find that the same managed care organization that denied reimbursement for life-saving interventions will approve reimbursement for life-ending medication.

Obtaining necessary services through HMOs has been particularly difficult for Medicare patients. For many elderly patients, the process required for peer review of an HMO's decision to deny them care is too confusing, involves long time delays, and ultimately ends up being a useless endeavor. These facts prompted a class-action lawsuit on behalf of the millions of Medicare beneficiaries who are in HMOs.[58]

The administration and the HMO industry contended that federal Medicare law "does not require an impartial review procedure for Medicare beneficiaries enrolled in HMOs before a termination or denial of their HMO services."[59] However, U.S. District Court Judge Alfredo C. Marquez found otherwise. He stated that Medicare patients in HMOs are entitled to immediate hearings whenever they are denied medical services.[60] The need for immediacy is particularly important for Medicare patients since, "When Medicare services are denied, they are often foregone and, depending on the medical condition, final adjudication may come too late

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57. *Comm'r of Corp. v. Takecare Health Plan*, (Cal. Dept. of Corp., No. 933-0290, OAH No. N 9412060, Oct. 29, 1996).

58. Between 1987 and 1995, the number of Medicare beneficiaries covered in capitated programs almost tripled. D. Berwick, *Payment by Capitation and the Quality of Care*, 335 New Eng. J. Med. 1227 (1996).

59. Pear, *Medicare Patients in HMOs Win Case*, N.Y.Times, Oct. 31, 1996.

60. *Grijalva v. Shalala*, No. 93-711, slip op. (D. Ariz. Oct. 17, 1996).

to rectify the situation, especially if the deprivation contributed to or resulted in unnecessary pain and suffering or death."[61]

In a strongly worded opinion, Judge Marquez noted that, even though there were regulations and guidelines that should have protected Medicare beneficiaries, they were not being followed. Complex and confusing in-house review procedures amounted to little more than "a 'rubber stamp' of the initial denial,"[62] which has "grave consequences because an HMO denial may mean the enrollee will go without medically necessary service."[63] He further noted, "Given the length of time it takes for further appeal of the HMO denial, deprivations will certainly have significant impacts on quality of life and some may even be life threatening."[64]

According to Judge Marquez, an HMO often "hides the ball"[65] and frequently doesn't let Medicare patients know that they have a "right to present additional evidence to the HMO for reconsideration."[66] He concluded, as did the District of Columbia Circuit Court in *Gray Panthers v. Schweiker,*[67] "Current procedures allotted to the elderly Medicare claimant, probably disadvantaged by disability and poverty, resemble playing against a stacked deck. . . ."[68]

Yet, it is not only patients that are detrimentally affected by the manner in which managed care organizations are presently operating. The impact on the medical profession as a whole and, along with it, the increased risk to patients which may not be evident for several years must also be considered.

61. Id., at 19.
62. Id., at 23.
63. Id., at 23-24.
64. Id., at 24.
65. Id., at 22.
66. Id., at 23.
67. *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980).
68. Id., at 172.

I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative that States Have the Right to Protect Residents from Assisted Suicide.

Credentialing procedures for those in the health care field are not new. For years professional organizations have established standards for credentialing physicians and other licensed independent practitioners. Historically, hospital review committees and other professional organizations examined a physician's educational background and professional competency to determine his or her ability to render appropriate medical care. With the advent of managed care, however, a new type of credentialing, known as "economic credentialing," was instituted. This type of determination about physicians' suitability to practice medicine is unrelated to the quality of care they provide or to their professional competency. Rather it is based upon economic criteria. Thus, if a physician is deemed to spend too much time with patients or found to be ordering too many diagnostic tests (even though the time and tests may have been medically appropriate), the physician risks dismissal from a health plan or physician group.[69]

Ironically, at the same time that managed care organizations have placed great emphasis on credentialing as it relates to competency in reducing costs, they have often paid far less attention to credentialing that would insure patient safety. For example, one HMO solicited physicians by mail and encouraged them to become providers within the managed care organization. The screening process for the physicians was limited to verifying that the physicians were licensed, had hospital medical staff privileges and were able to prescribe narcotics. No personal interviews and no investigations about prior medical malpractice claims were conducted.[70]

Although an increasing number of physicians are alarmed by the harmful impact of managed care upon professional practice, this may not be enough to deter young physicians,

69. See, e.g., Cal. Med. MEDFAX, (So. Cal. Ed.) Jan. 8, 1996, at 2.
70. See, e.g., *Harrell v. Total Health Care, Inc.* 781 S.W. 2d 58 (Mo. 1989).

just entering medical practice, from embracing managed care. Due to the increased competition for health care dollars and the decline of the traditional fee-for-service practice, many physicians feel compelled to contract with managed care firms out of a sense of economic survival. Since large managed care firms offer employers a reduced rate for employee health coverage, and since these firms, in turn, contract with physicians, physicians who practice in fee-for-service are being left high and dry. Thus, a young physician who is entering into practice with the burden of heavy medical school debts may find that the economic security of a managed care contract — flawed though it may be — is the only economically viable option.

Indeed, with managed care beginning to dominate the entire health care delivery system, doctors may find themselves forced to choose between practicing managed medicine or not practicing medicine at all.

III. POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING MAKE IT ABUNDANTLY CLEAR THAT STATES HAVE BOTH A VITAL AND A RATIONAL INTEREST IN PROTECTING THEIR RESIDENTS BY PROHIBITING ASSISTED SUICIDE.

As providers in a managed care environment, many physicians will continue to be sincerely motivated by respect for patient well-being and autonomy, but the cost factor will always lurk in the shadows. As precarious as the situation resulting from managed care is at present, it would only become worse if physician-assisted suicide were to be considered a legitimate and legal medical option. If states are not permitted to protect their citizens from assisted suicide, the managed care provider would, in many cases, become the managed death provider. Dr. Daniel Sulmasy described the link between managed care and assisted suicide in concise terms when he stated that "the movement toward managed care as a preferred means to control health care cost and the

movement toward managed death as the preferred means to control terminal suffering are strong, active and current."[71]

To gauge the accuracy of Dr. Sulmasy's warning, one need only reflect on the vise-like pressure placed on doctors that has been described above and examine what has happened when voters in the state of Oregon approved Measure 16, the "Death with Dignity Act," which permits assisted suicide under certain conditions.[72] Less than five weeks after Measure 16's passage, Oregon's Medicaid director, Jean Thorne, said that assisted suicide would be covered under a part of the Oregon Health Plan called "comfort care."[73] Noteworthy was the fact that, as assisted suicide was being scheduled as a covered service, other existing services for poor Oregonians were being scrutinized for cuts.[74]

While some may question any direct relationship between the passage of Oregon's assisted suicide measure and attempts to cut health services, the cost effectiveness of hastened death is as undeniable as gravity. The earlier a patient dies, the less costly is his or her care. In any event, dead patients do not threaten managed care profits.

Likewise, there are varied opinions about any link between cost of care and euthanasia in the Netherlands where thousands of assisted suicide and euthanasia deaths occur annually, and more than one half of those deaths are not requested by the patients who died.[75] Of note is the cost of

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71. D. Sulmasy, *Managed Care and Managed Death*, 155 Arch. Int. Med. 133 (1995). Although Sulmasy refers to managed death for "terminal suffering," it is highly unlikely that assisted suicide would or could be limited to those whose conditions are diagnosed as "terminal." See e.g., E. Chevlen, *The Limits of Prognostication*, 35 Duq. L. Rev.337 (1996); and Marker, supra note 13, at 90-94.

72. The Oregon statute was enjoined by federal district court Judge Michael Hogan the day before it was to take effect. See *Lee v. State of Oregon*, 891 F.Supp.1429 (D. Or. 1995).

73. Postrel, *State Could Cover Assisted Suicide*, Statesman Journal (Salem, OR), Dec. 1, 1994, at A1.

74. Deitz, *Lawmakers May Trim Health Plan*, Statesman Journal (Salem, OR) Jan. 9, 1995.

75. Marker, supra note 13, at 85. Although the Dutch practice of physician induced death began with the intent of offering patients greater con-

performing euthanasia in the Netherlands which, Dutch euthanasia practitioner Dr. Pieter Admiraal has explained, can be performed for about five guilders whereas the cost of a single day of hospitalization is five hundred guilders.[76] Perhaps coincidentally, perhaps not, the Netherlands has the lowest per capita health expenditure in all of Europe.[77] According to Dr. Jeffrey Jackson of the Walter Reed Army Medical Center in Washington, this low per patient expenditure "reflects an ongoing effort to ensure that Dutch physicians are sensitive to cost and practice economically prudent medicine."[78]

CONCLUSION

Managed care has been referred to as a "work in progress"[79] which may eventually work very well if improvements are made. But those improvements could take years as legislatures and courts wrestle with the complex problems and conflicts of interest inherent in managed care programs. Meanwhile, the issues before this Court demand immediate resolution.

This Court faces the momentous task of determining whether the United States Constitution precludes states from enacting statutes prohibiting assisted suicide. Proponents of a constitutional right to have a doctor actively participate in assisted suicide argue that the issue before this Court is one of individual rights. But their assertions ignore the context within which that activity would be undertaken.

NOTES *(Continued)*

trol over their own deaths, the practice of euthanasia and assisted suicide has actually increased the power and control of doctors, not patients. See generally: H. Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* (New York: W.W. Norton & Co.1997).

76. R. Marker, *Deadly Compassion* 146 (New York: Wm. Morrow & Co. 1993).

77. Reuters Health News Service, *Lessons on Healthcare Reform from the Dutch*, July 22, 1996

78. Id.

79. P. M. Ellwood, *Managed Care: A Work in Progress*, 276 J.A.M.A. 1083 (1996).

This Court must decide the issue based not only on abstract notions of individual liberty but on the reality of the environment within which personal and medical decisions would be made. Only then can it determine whether the state laws under consideration sufficiently support valid state purposes and thus, pass constitutional scrutiny.

This brief has demonstrated that the current health care environment is evolving into a system defined by cost-cutting imperatives and dominated by a form of health insurance known generically as managed care. Further, it has shown that the very purpose of managed care, which is to reduce the cost of providing medical care, is accomplished, in large part, through a system that rewards reduced levels of care.

In such a milieu, the kind of treatment that modern medicine is capable of providing (e.g. pain control, symptom management, and treatment of depression which is often essential to patient well-being and a desire to continue living) can be difficult to obtain. This problem would be exacerbated if the less costly and less time consuming "service" of assisted suicide were available mandatorily as a constitutional right. This could well create scenarios in which agonized and depressed patients would elect to have their deaths facilitated since their relievable suffering went unalleviated because of their health providers' financial imperatives. Moreover, forcing physicians to elect between providing patients with care, at the risk of having their own incomes reduced, and suggesting assisted suicide as a cost saving measure, would place doctors in an ethical and moral conundrum. The deleterious impact of that would be felt by the medical professionals, patients, and society as a whole.

This is the reality with which the Court must grapple.

In sum, legalizing physician-assisted suicide in a health care system in which financial incentives would favor denying care and hastening death would create a profound injustice.

Rather than serving the noble cause of individual liberty, it would make a mockery of freedom, since the "choice" to commit assisted suicide would, in many cases, have essentially been predetermined by managed care's financial imperatives.

Decisions to die would often be based, not on the inability of physicians to control pain and limit suffering but on pecuniary determinations.

That being so, state legislative decisions to prohibit assisted suicide are constitutional since they serve vital and rational state interests. Such laws ensure that managed health care does not devolve into a system of managed death. They protect and reinforce the traditional ethics of the health care profession. They strengthen the bond of trust essential to the patient-physician relationship by preventing doctors from being tempted to end patients' lives in order to promote their own financial ends. Perhaps most importantly, they reinforce the essential moral concept that human beings are not commodities, that lives cannot be measured in pecuniary terms, and that rich or poor, powerful or weak, no one should be sacrificed to benefit financial bottom lines.

Respectfully submitted,

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Supreme Court of the United States

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DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

and

STATE OF WASHINGTON, CHRISTINE O. GREGIORE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF PROLIFE NURSES, NATIONAL ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION IN LONG TERM CARE, PHILIPPINE NURSES ASSOCIATION OF AMERICA, SCHOLL INSTITUTE OF BIOETHICS, CALIFORNIA NURSES FOR ETHICAL STANDARDS IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*:

The decisions of the Courts of Appeal damage the liberty and property rights of nurses.

Letters of the parties consenting to file this brief *amici curiae* have been filed with the Court. Descriptions of each group filing this *amici* brief are set forth in the Appendix.

By striking state laws criminalizing assisted suicide, the decisions of the Courts of Appeal, if affirmed, would make assisted suicide legal. The *amici curiae* will be uniquely and directly affected by the Court's decision in this case. To demonstrate their unique interest, *amici* will present evidence that nurses would be 1) involved, and 2) detrimentally affected, if assisted suicide were made legal.

The decisions of the Courts of Appeal on review grant an entitlement not only to "physician-assisted suicide" but also (a fact unknown to many) to "nurse-assisted suicide." The practitioner most likely to be with the patient as he dies, is his nurse. A large difference exists between the professions of nursing and other professionals in illness care, regarding the care of terminal patients. The patients who are the subject of assisted suicide almost always require nursing care, not always medical care. At the very time when medicine may have little to offer the patient, the nurse can give comfort, concern, and care. The interest of nurses in what happens to their dying patients is unique, even among other professionals.

The nurses' interest differs from other professionals in another way: nurses are almost always employees. They will not have the luxury that other professions might have, abstractly and coolly to deliberate on whether to assist a patient in suicide. Nurses rarely can choose their patients; they are assigned to them. Because of their societal and employment status, nurses would be vulnerable to pressures to assist in suicide against their professional or ethical judgment. They are often in the unenviable position of being responsible for executing decisions in which they have no voice. The nursing coat of arms in some instances might well read: "Responsibility without Authority."

The effect of inculpating nurses in the self-killing of their patients will not be addressed by any other *amici* or Party. The effect is this: If assisted suicide is made legal, nurses will be asked to assist suicide. All nurses care for patients who die, and some of their patients might die by prescription. That nursing care would be nurse assistance in suicide, because the definition of "assist" cannot be narrowly limited only to providing medication. Those nurses and thus the whole profession would be inculpated in nurse-assisted suicide. Further, Nurse Practitioners (NPs) in several states now legally prescribe the medications that would be used to cause death in patients.

The Nurses' concern for their *patients* who would be harmed, will be addressed by other *amici*. Nurses add that the harm done to the profession of nurses, the largest group of practitioners who care for patients, would affect not only current patients but all who would need nursing care in the future.

All nurses would be involved intimately in the death of their patients who might self-kill. The decision of one of the Courts of Appeal contemplates this, together with an assumption that at some future time euthanasia may be delegated:

> "We recognize that in some instances, the patient may be unable to self-administer the drugs [for suicide] and that administration by the physician, **or a person acting under his direction or control** may be the only way the patient may be able to receive them." [Emphasis and material in brackets added]. *Compassion in Dying v. State of Washington*, 79 F.3d 790 at 831 (9th Cir.1996).

The inevitable inculpation of nurses in legal assisted suicide would erode the personal and professional ethics of nurses, expose them to criminal and civil sanctions, and destroy the confidence of the public in the profession. Thus the nurses' rights to liberty and property in the practice of their profession would be violated.

SUMMARY OF ARGUMENT

The decisions of the Courts of Appeal grant the entitlement to suicide with assistance and approval and thereby deny liberty and property rights of nurses in their profession, damaged irrevocably by nurse assistance in the deliberate deaths of patients. Nurses would be 1) inculpated, and 2) harmed, by legal assisted suicide:

1. Under legal assisted suicide, nurse practitioners and all other nurses would be inculpated in nurse-assisted suicide. One association of nurses already has advised its members that nurses would be involved in assisting suicide if it were legal.
2. Legal assisted suicide would harm irrevocably the ethical and legal basis of the nursing profession; current ethical standards of nurses would be eroded; and the public's perception of the profession would deteriorate, all causing damage to the liberty and property rights of nurses in practicing their profession.

ARGUMENT

To commit suicide with assistance and approval is not a right but an entitlement. Making assisted suicide legal does not merely allow the ability to do an act by one person, but confers the power to involve another person in the act.

Nurses leave to other *amici* the elaboration of the certain fact that the vast majority of people who seek suicide are psychologically impaired. Even terminal patients in pain do not seek death (and *amici* assert this pain can be relieved, under current standards of care). E.J. Emanuel, *et al, Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, 347 Lancet 1805 (1996).

Terminally ill patients who seek to die are almost invariably depressed and ambivalent about dying, and those patients can be helped with medication. If encouraged, such ambivalent patients will choose to live. For the rare patient who is terminal, competent, non-depressed and seeking suicide with help (and even that patient is likely ambivalent about dying):

Before these Courts of Appeal decisions, prescriptions have been written with knowledge that their purpose was suicide. Though that information has been acknowledged, no prescribers have ever been convicted of assisting suicide. T.H. Stone & W.J. Winslade, *Physician-assisted suicide and euthanasia in the United States*, 16 J. Leg. Med. at 492 (1995).

The aim of making assisted suicide legal, then can be seen. It is not merely to allow a prescription for the few competent, terminal, non-depressed patients who would commit suicide with such drugs. Instead, it provides a prescription *with approval of its purpose*. This prescription would be visible evidence of approval of the act from the doctor or nurse practitioner. Legal assisted suicide confers the entitlement to suicide with approval, by inculpating the professions. The intent is to give to the act the imprimatur and approval of the law, and of the professional.

The tacit tolerance of assisted suicide already creates the perception that some special cases exist that warrant assisted suicide. This tolerance would become explicit if legal. The nurse would be forced to act either in compliance with her conscience (to safeguard her patient, profession, and opinion of herself), or to act in compliance with what would then be the law. She would have to be silent or even assist suicide.

1. Legal assisted suicide would inculpate all nurses in assisted suicide, denying nurses the liberty and property interests in their profession.

The relationship of nurses to their patients has been called a social contract with the public. That is, the public/patient knows in general what a nurse is, and what she is expected to do. People who are currently in the profession entered that work with the knowledge of, and expectation of, what their work would be. They have a property interest in their occupation; and they have a liberty interest in being able to practice the profession as it exists without arbitrary government interference. Both interests have been found to rise to the level of fundamental rights, deserving Constitutional protection.

> " . . . [T]he right to work for a living in the common occupations of the community is of the very essence of the personal freedom and opportunity that it was the purpose of the Amendment to secure."

Truax v. *Raich*, 239 U.S. at 41 (1915); and

> "[T]he right to hold specific private employment **and to follow a chosen profession** free from unreasonable governmental interference comes within the 'liberty' and 'property' concepts of the Fifth Amendment."

Greene v. *McElroy*, 360 U.S. at 492 (1959) [Emphasis and material in brackets added].

The liberty and property interests asserted here are not merely in a specific job, though specific employment also may be endangered for the nurse who will not participate. The nurse who will not participate in assisting suicide cannot merely go to another nursing job that is unaffected by legal assisted suicide. Any and all nurses would find their profession damaged by the inculpation of nurses in assisted suicide. All jobs, all nurses, would be tainted.

The practice of nursing does evolve and change; but the underlying values expressed in the ethics of nursing, and enforced in the minimum of the law, have not changed in thousands of years. The *amici* assert that it has not ever been the legitimate work of their profession to assist patients to kill themselves. Legal assisted suicide would make those acts part of the work of nurses.

Courts have always considered the effect of their decisions on all the people involved in a case. Under these decisions, the nurses are immediately and intimately and detrimentally involved. In particular, the impact of their decisions on the integrity of the professions has been of major concern to courts. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980).

Other courts have expressed concern for nurses asked to assist in causing death in their patients (in the case quoted below, by denying nursing care).

> I find it difficult to understand how we can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care. [Such an order] may impinge on the privacy rights of those nursing professionals.

In re Jobes, 529 A.2d at 464 (N.J. 1987) (O'Hern, J., dissenting). [Material in brackets added].

Another court worried about the ethics of nurses asked to assist in deliberately dehydrating to death a comatose patient:

> . . . for almost all concerned the adoption of the proposed course will be a merciful relief, [but] this will not be so for the nursing staff, who will be called on to act in a way which must be contrary to all their instincts, training and conditions. They will encounter the ethical problems, not in a court or in a lecture room, but face to face.

Lord Mistill, House of Lords. *Airedale NHS Trust (Respondents)* v. *Bland* (Acting by his guardian *ad litem*) (Appellant) London: House of Lords, 1993 [Material in brackets added].

a. Legal assisted suicide would inculpate nurse practitioners as prescribers of drugs used in suicide.

If assisted suicide were legal, nurse practitioners in many states would be affected in exactly the same way as physicians. They would be seen as practitioners who could prescribe death instead of promoting life. In some states nurse practitioners potentially can prescribe all the drugs that patients seeking to suicide most likely would be prescribed to kill them. Drugs that might be prescribed are used at present for pain, sleep, anxiety, or depression, all of which categories some nurse practitioners legally can prescribe now. See, for example, Or. Rev. Stat. 678.385.

Patients who could legally obtain drugs for the purpose of suicide from physicians could get a prescription for the same or similar drug from a nurse practitioner. This is so, even if the NP technically could not prescribe for the *purpose* of suicide. If prescriptions from the physician for the purpose

of assisted suicide were legal, patients would be encouraged (and perhaps even more likely) to ask for the same drugs from their nurse practitioner. Patients who formerly might not have sought a prescription for suicide might be encouraged to do so if it were legal. The legality of the prescription would remove the stigma from suicide or at least spread it onto the prescriber.

Nurse practitioners in the future likely would be included as "prescribers" if assisting suicide were legal. The equal protection clause of the Fourteenth Amendment to the Constitution would prohibit the exclusion of Nurse Practitioners from prescribing drugs for self-killing. The limitation of such prescriptions to physicians would discriminate without rational basis, since nurse practitioners too could prescribe the drugs most likely to be used to kill the patient.

To assert that the prescription of killing drugs could be limited to physicians because they are better qualified to judge the mental status of the patient, has no factual basis. Comparison of the curricula of their respective educational programs would demonstrate that nurse practitioners (especially those working in mental health) are even more likely than doctors to have been educated in psychosocial components of care. Thus nurse practitioners are at least as able as physicians to assess patients for their competency in making a request to die. Nurse practitioners would be inculpated in legal nurse-assisted suicide as prescribers. Their exclusion will not meet the rational basis standard of Amendment Fourteen of the Constitution.

Nurse practitioners unwilling to assist the patient in suicide likely would be required to transfer medical records to the next practitioner chosen to assist suicide, just as physicians would be. This participation would be required, regardless of the religious or moral or professional objections of the nurse to inculpation in the self-killing. The nurse's objection that suicide was inappropriate for this patient, based on her assessment of the patient, would be no bar to enforcing such

transfer of records. An example of such requirement to transfer patient records in a law with "safeguards" as recommended by the decisions of the Courts of Appeal, is Oregon Ballot Measure 16, Section 4.01(4).

b. Nurses other than nurse practitioners would be affected by legal assisted suicide.

(1) The practice of every nurse would be changed by legal assisted suicide (which seeks to solve a nonexistent problem).

Legal assisted suicide would affect all nursing practice; most nurses care for terminal patients on a daily basis. Some of those patients (those who are depressed and ambivalent) might seek suicide with assistance. Participating in assisted suicide would become part of the practice of nursing. The consequences of legal assisted suicide noted below support that conclusion, and it is admitted by the position of the Oregon Nurses Association (ONA) discussed more fully below. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

If assisted suicide were legal, according to the ONA paper discussed below, even the nurse who is morally opposed to assisted suicide would be required to inform the patient of his right to referral to a physician (or nurse practitioner) who would prescribe a lethal dose. For some nurses, supplying this information would be assisting the patient's suicide. They would assist, as surely as did German nurses under National Socialism assist euthanasia. Those German nurses identified some children as retarded, knowing the result of the diagnosis would be death.

From the research done on attitudes and behavior of patients who are terminally ill, it is evident that the Courts of Appeal have written law to solve a problem that does not exist. Data cited above (Emanuel) show that patients who seek suicide are depressed and at least ambivalent about their wish to die. Practitioners are notoriously bad at diagnosing

and treating depression[1] (a reason to educate practitioners, not a reason to assist depressed patients to suicide). The data also show that competent terminal patients, even those (unnecessarily) in pain, are very unlikely to seek suicide.

According to research studies, a large majority of patients want heroic efforts made if they die. They may overestimate the success rate of heroic efforts, but patients who are very seriously ill, even those that might be classed as "terminal," want to live. R.S. Phillips *et al, Choices of seriously ill patients about cardiopulmonary resuscitation: correlates and outcomes*, 100 Am. J. Med. 128 (1996).

At present, the nurse's duty toward a depressed patient dying in pain is to alleviate the pain and treat the depression, both remediable conditions. If assisted suicide were made legal, the nurse's practice would be changed, perhaps to assist the patient to suicide in order to relieve depression and pain. Effective (non-lethal) treatment is available right now for depression and pain. *Amici* know it is not necessary to end the patient, to end his pain.

The Courts of Appeal have confused withdrawing treatment that patients do not want, with suicide, assisted suicide, and euthanasia. Researchers too have confused refusing treatment with suicide, resulting in studies that seem to indicate that intensive care nurses already assist suicide or euthanize patients. D.A. Asch, *The role of critical care nurses in euthanasia and assisted suicide*, 334 N. Eng. J. Med. 1374 (1996). In reality, only treatment that the patient rejects is removed. Often the treatment rejected would not have prolonged the patient's life in any event. The public (including jurists and researchers) overestimate also the success rate of medicine and nursing in prolonging life with heroic efforts.

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[1] Purported safeguards in legislation such as those in Oregon's Measure 16, ask the practitioner to refer the patient who may be depressed for counseling. But many practitioners cannot recognize the diagnosis in the first place, so they cannot refer. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) p. 127.

Though it may be blurry to the Courts of Appeal, the line is very clear and bright between withdrawing treatment which would not prolong life, and actively causing death. Nurses are adamant that care that is not useful, and is not wanted, be ended. The nurse is very often the patient's greatest advocate in such situations. She will take whatever measures are needed to see that the patient's wishes are honored. These measures may include conversations (even confrontations) with doctors, ethics committees and employers. But for the nurse, it is a thousand leagues distance from honoring her patient's wish to stop treatment – to being her patient's agent of death.

Under legal assisted suicide a nurse would encounter a family pressuring the terminal patient to die (subtly or not, and done for the patient's benefit or not). Currently, this behavior might rise to the level of neglect or abuse of an elderly or dependent patient, and the nurse's obligation is to report it. Under legal assisted suicide, the nurse's practice would be changed (perhaps to refer the patient and family to a practitioner who would prescribe a lethal dose).

Under legal assisted suicide, federal law might require nurses to inform the patient who is even possibly "terminal," of his right under state law to assisted suicide. The Patient Self-Determination Act 42 U.S.C. Sec.1395cc(a)(1) *et seq.* requires recipients of Medicare funds (hospitals, skilled nursing facilities, home health agencies, and hospice programs) to provide information to each patient concerning

> "an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."

Even government employers may require practitioners to give information preferred by the employer's policy. *Rust* v. *Sullivan*, 500 U.S. 173 (1991). Private employers surely would be able to dictate information to be given. For employers of nurses such as managed care companies or their contractors (virtually all employers of nurses are included in the latter category), the patient's suicide or euthanasia might

be a very cost effective procedure. If the procedures were legal, nurses would be under pressure to assist suicide and euthanize. Nurses might be expected to suggest such "alternatives" to expensive care.

Nurses could be directed by their employers to tell patients that help in killing themselves is available, or be at risk of losing their jobs. Some nurses from strong religious and ethnic tradition, and other nurses who also place primary value on the life of the patient, would be especially at risk. If legal, such nurses who work on oncology and AIDS units, in long term care, hospice, and home health would find their job opportunities limited if they declined to participate in assisted suicide.

Nurses could be forced to choose between job and conscience in a time of shrinking job opportunities in nursing. Most nurses work as "at will" employees, vulnerable to covert and overt pressures to conform to employer goals. Nurses are career professionals, whose jobs usually provide the main source of income in their families. Many could not afford the luxury of maintaining their ethical standards at the cost of losing their livelihood.

(2) Hospice and home health nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some hospice or home health nurse would visit her patient to find he had obtained a massive overdose of drugs. (If legal, it would be considered not an overdose but a "correct" dose to kill himself.) Before legal assisted suicide, the nurse would have assumed her duty was to help the patient live. After legal assisted suicide, the nurse's duty could conceivably be to counsel how best to take the drugs to assure death.

Under legal assisted suicide, some nurse who made a visit to check on her patient would find the patient had already ingested the prescribed overdose. (If legal, the dose would be called the "correct" dose – to kill the patient.) Currently, the nurse's duty is to call 911 and resuscitate.

Under legal assisted suicide, the nurse's duty might be to remain passively with the patient/family until the death. The ONA paper [cited below] suggests that if no other nurse were available, legal assisted suicide would create a duty to stay passively with the patient until death, regardless of the nurse's strong intent *not* to assist suicide.

The nurse whose patient would die by legal prescription would be inculpated in the death, because such a death is not so swift or sure or painless as might be assumed.[2] The patient may not die immediately or even within several hours or days. In addition to taking the prescription, proponents of suicide advise placing a plastic bag over the patient's head to assure asphyxiation if the patient awakens. This course of events is said to be not uncommon.

The ONA paper below suggests that even the nurse who did not wish to assist the patient in suicide, still would have to assume the patient's "end of life care" if assisted suicide were legal. If she were unable to transfer the suiciding patient to another nurse, she would have no choice but to participate.

Under legal assisted suicide, the nurse's duty might be changed horribly, perhaps extending to placing the plastic bag over the patient's head if the patient were unable to do so.

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[2] Prescribers for legal assisted suicide would not be competent to prescribe for a totally new purpose – to kill. To illustrate the problem: Excellent pain control measures are available, but many physicians and nurse practitioners are still unable to prescribe appropriate pain control for terminal patients. (This is not an excuse to kill the patient to relieve the pain, but a reason for more education of prescribers about the near 100% effective relief available.) Considering that current failing, it would be long before prescribers were good at killing. There is no scientific basis for this practice and doctors and nurse practitioners have had no experience in doing it. A new era of research would result if assisted suicide were legal. Such investigation of how to kill people yielded the Guillotine in the 18th Century, and the gas chamber in the 20th. It might well be asked what rough science slouches toward the 21st Century to be unearthed.

Eyewitnesses assert that it is sometimes necessary to hold the suiciding person's hands as he smothers, to keep him from forcefully removing the bag. The nurse's duty could extend to doing that.

If assisted suicide were legal, a hospice or home health nurse would find a suiciding patient alone and with no plastic bag. Currently the nurse's duty is to call 911 and resuscitate. Under legal assisted suicide the nurse's duty might be changed, to placing a plastic bag herself as noted above. Or her duty might be seen as passive, to leave the patient in a comatose state, visiting later to see if the patient died in the interim. It is highly impractical to say that the nurse would be obligated to stay with such a patient. Patients in a coma may take 11-14 days to die of dehydration (known from the experience of deliberately dehydrating to death, non-dying patients). Ruth Phillips, *The legacy of Nancy Cruzan,* 6(2) Living World 16 (1992).

A failed attempt could result in a very damaged patient, which would encourage or even mandate the nurse to ascertain that her patient does not fail. Nursing practice eventually might extend to directly killing the patient who failed in the suicide attempt. Legal assisted suicide does not prohibit active euthanasia; initially, it merely does not "authorize" it. For example see Oregon Ballot Measure 16, Section 3.14.

(3) Hospital and long term care nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some patients prescribed a lethal dose would choose to take the drug in the hospital or long term care facility. One proposed "safeguard" legislation recognizes that possibility on its face.

> "If the patient [who wishes to suicide] is an inpatient at a health care facility, one of the witnesses [to the request for suicide] shall be an individual designated by the facility."

Oregon Ballot Measure 16, Section 6, "FORM OF THE REQUEST." [Material in brackets added.] The nurse designated by the facility would be faced with assisting suicide at least to the extent of witnessing the patient's request, regardless of her moral, ethical and professional objections.

If the nurse on duty in a hospital or other inpatient facility knows of the patient's plan to suicide beforehand, her duty might change from trying to save the patient's life – to assisting with his death. Currently the nurse continues nursing care for the patient who is dying; turning the patient, suctioning secretions, administering medications, etc., to help the patient *live* comfortably. Under legal assisted suicide, the nurse's practice would change. The duty logically might be to do whatever would cause the patient to die sooner.

Under legal assisted suicide, the "worse" the nurse by present standards (that is, the faster and better at killing), the better for the patient. The "better" the nurse by present standards (that is, the more life-saving, caring), the worse for her patient under legal assisted suicide. The *amici* assert: This situation stands nursing practice on its head.

These vignettes look macabre, but they are not worst-case scenarios; they are the likely situations that nurses would encounter if the Courts of Appeal are affirmed. Immediately, intimately and inextricably, nurses would be inculpated in assisted suicide.

Nursing "care" would be redefined to include the killing of the patient, and assistance as the patient self-kills. Nursing theory would be developed to teach students how to "care" (or, in every accurate usage of the word, how *not* to "care") for patients committing suicide. Continuing education would be needed for current nurses, on how to assist patients being killed by self-administration of drugs. If assisted killing were extended to people unable to self-administer the drugs (as would be likely), nurses would be taught to kill patients directly.

Nursing education and curricula would be changed to incorporate the "new" ethic and law and nursing practice: Some patients would be given good care. Some patients' "good care" would include giving them prescriptions to kill

themselves. And some patients' "care" would include killing them.

c. Anticipation of legal assisted suicide in one state has caused its nurses to accept involvement.

The threat of legal assisted suicide in one state already has prompted a paper in which the nurses association accepts that nurses will be involved in their patients' suicide. In anticipation that legal assisted suicide would be implemented, and to prepare their members for that reality, the Oregon Nurses Association (ONA) adopted a position statement to guide nurses in the care of terminal patients under legal assisted suicide. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

The ONA document asserts that the nurse's role under legal assisted suicide would be "to share information about health choices **that are legal**." [Emphasis added] Oregon Nurses Association, p. 3. This statement is evidence that nurses will be involved if assisted suicide is legal. Nurses would be expected to teach patients about the option of killing themselves. Mere legality (not any higher ethical standard) would be the defining parameter of the nurse's behavior.

Theoretically, under the Oregon "safeguard" legislation which proposed to make assisted suicide legal, the nurse could refuse to care for a patient who chooses to kill himself. But the ONA paper admits that if she couldn't transfer the patient, "the nurse has the responsibility to provide for ongoing end of life care." Oregon Nurses Association, p. 3. Transfer might be impossible if the nurse discovered the suicide attempt after the patient had taken the poison. Requesting and securing a replacement nurse from her agency (if even granted) could take longer than the patient had to live. Nurses could not opt out of legal assisted suicide, no matter what the language of any "safeguard" legislation adopted by a state legislature.

Nurses are competent to make professional judgments about the mental and physical status of their patients that would affect the appropriateness of a request for suicide.

Further, they are competent to make moral judgments for themselves, about the appropriateness of suicide for any person at any time. Regardless, under legal assisted suicide, the ONA paper asserts that the nurse would be involved and would be muzzled:

> "You may not subject your patients or their families to unwarranted, **judgmental** comments or actions because of the patient's choice [to kill himself]."

Oregon Nurses Association, p. 4. [Emphasis and material in brackets added].

The nurse would be involved, her professional judgment would be thwarted and her freedom of speech compromised under legal assisted suicide.

The ONA position paper is evidence that legal assisted suicide would inculpate nurses fully in assisted suicide, and to the detriment of the practice of the profession.

2. Legal assisted suicide would harm the ethics and law of nursing; the threat already has done harm.

a. Legal assisted suicide would erode the ethics and law of nursing.

The inculpation of nurses in assisting patients to kill themselves causes the degeneration of the ethics and law of nursing, which are based on six values (elaborated below): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. The position of the American Nurses Association (ANA) states the ethical foundation of nursing practice:

> "The goals of nursing are the promotion, maintenance, and restoration of health, the prevention of illness, and the alleviation of suffering. The social contract between nursing and society to meet these goals is based upon a code of ethics that is grounded in the basic ethical principles of respect for persons, the noninfliction of harm, and fidelity to recipients of nursing care. These principles command that nurses protect or preserve life, avoid doing harm, and create a relationship of trust and loyalty with recipients of nursing actions."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The ethical standards of conduct (a higher ideal) are used by lawmakers in making lower, legal minimum mandates. Nursing law is the minimum enforcement of nursing ethic. It is the arbitrarily drawn line that separates desired behavior (ethics) from mandated behavior (law). The law exists to guide people who have no higher ethic. People who will not do right voluntarily, can be made to do at least a minimum of "not wrong" with law.

Those people, and others who have no moral compass, will take the law as the highest, not the lowest, standard of behavior. For them, the law becomes the ethic. "It's legal, therefore it must be ethical" is the reasoning. If the nurse who assists suicide were acting legally, some then would assume that she was acting ethically, too.

As noted below regarding nurse participation in executions, the nursing profession nationally has not succumbed to that lowest level of behavior. The national nursing associations, such as the American Nurses Association (ANA) and the National Association of Prolife Nurses, set and promote professional standards of ethics. Those standards cannot be varied according to popularity poll, nor may they descend to whatever acts the popular will has made temporarily legal. As an analogy to assisted suicide: Nursing leaders have suggested that nurses who participate in executions – even if the act is legal – are so far below the ethical standard required of nurses, that their licenses should be revoked.

Assisting a patient to kill herself, merely because it is legal, should not change the standards of nursing practice and ethics; but it would. The legal standard of nursing would be so low that merely to meet it would violate nursing ethics. The standard of nursing ethics and nursing practice would inevitably be ratcheted down to a lower level commensurate with the law.

Some nurses would do whatever is legal. That is why it is not sufficient to say that nurses can protect the ethics of the nursing profession simply by voluntarily refusing to participate in legal assisted suicide. Unlike the isolated participation

in legal executions by a few nurses, *all* nurses are intimately involved in the lives and deaths of dying patients. Under legal assisted suicide, nurses would be inextricably inculpated in their patients' suicides. The erosion of the law would corrupt the ethic correspondingly. Law would lead instead of follow the ethic, and would irreparably harm the profession of nursing.

The ethics and the resulting law of nurses are based on the following six values held by nurses (and all the illness care professions): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. J.K. Hall, *Nursing Ethics and Law* (1996). Discussion of each value follows with its resulting ethic and law and the changes that legal assisted suicide would cause. As the law deteriorates, so do the ethics.

DOING NO HARM

Legal assisted suicide would damage the nursing ethic and law based on the value, *Doing No Harm* (Non-maleficence). That value is enforced by criminal law, civil intentional tort law and licensure law. Currently, nurses can be prosecuted under their licensure law which in most states allows license revocation for conduct which can be characterized as gross incompetence or gross negligence. See, for example, Or. Rev. Stat. 678.111(b). Presently, assisting deliberately caused death in a patient could be characterized at least as gross incompetence or as gross negligence, if not intentional harm. If assisting suicide were legal, the nursing licensure law would have been dramatically changed.

Assisting deliberately caused death now would surely be "conduct derogatory to the standards of nursing," also grounds for licensure discipline in most states. See for example, Or. Rev. Stat. 678.111(f). Again, legalizing assisted suicide would change the licensure law. As noted above, the standards of nursing have been national parameters, not community or state standards subject to the vagaries of what lawmakers set. But the law will lead those who have no ethical guide, and if assisted suicide is legal, nurses who

assist will seem to meet the minimum standard of nursing practice.

Presently, the nurse whose terminal patient is being pressured to commit suicide may be obligated to report that as neglect or abuse of an elderly or dependent patient. See for example Or. Rev. Stat. 410.610 *et seq.* (elderly) and Or. Rev. Stat. 441.630 *et seq.* (nursing home). If assisted suicide were legal, such encouragement might be considered the right thing for family or nurse to do.

Under legal assisted suicide the enforcement of these laws preventing harm to the patient would change. "Safeguard" legislation (such as that passed in Oregon) would have to provide that nurses would not be subject to criminal or civil liability or professional disciplinary action for assisting suicide. Such law would erode the authority of the board that regulates nursing, and any other agencies that enforce the law that prohibits and punishes harm to patients. Allowing nurses to assist in suicide would erode the minimum ethic enforced by the law, and correspondingly lower the standards expected of nurses generally.

DOING GOOD

The nursing ethic based on the value *Doing Good* (Beneficence) is enforced in malpractice law. Currently, when nurses fail to do good (as a reasonable prudent nurse would do), even unintentionally, they are subject to liability. Currently, nurses are not relieved of their own liability for their actions by physician orders and actions or patient wishes; nurses are morally and legally liable for their own malpractice. See generally, *Nurse Liability for Own Malpractice*, 51 ALR 2d 970.

Legal assisted suicide would change the nursing malpractice law. The standard of care of the "reasonable prudent nurse" would be changed from obligation to *save* the patient's life, to obligation to help *end* it in some situations. As noted above, under legal assisted suicide, the nurse would be obligated to inform the patient about the availability of assisted

suicide. Regardless of her personal moral convictions or professional assessment that the patient can be helped short of suicide, the patient or survivors might bring an action for subsequent pain and suffering based on a negligence theory if she did not so inform.

On the other hand, nurses who did refer or assist the patient who sought assisted suicide, might also be liable. The theory of liability could be failure to assess adequately for depression or decisional capacity, or failure to challenge the prescriber's assessment and prescription if they were faulty.

The family member or the estate who learns about the nurse's involvement in the attempt might have a cause of action for malpractice or wrongful death. The family might notify the licensure board of the nurse's action, alleging failure of nursing care. (Though as noted above, the licensure board might be powerless to enforce standards after legal assisted suicide.)

BEING FREE

Legal assisted suicide would damage the nursing ethic based on the value *Being Free* (Autonomy), enforced by consent law. The nurses leave to other *amici* to elaborate on the obvious fact: The patient's autonomy must *not* be honored and he must be protected from himself, if he is not competent to make decisions. That is the situation if the patient is depressed or suffering from mental illness, which almost all suicidal patients are.

The right of the patient to refuse treatment is stronger than the grant of an entitlement (as in legal assisted suicide), but even that power of refusal is not absolute. The right is conditioned on the impact on other people; for example, the power to refuse a transfusion may be conditioned on the patient's responsibility for another person.

Nurses have some rights to their own autonomy. The patient's demand for treatment which transgresses the professional's ethics cannot be honored. For example, the patient's demand to remove a healthy body part (because the person wanted to qualify as disabled) must be declined by the ethical

physician. Even an *un*ethical doctor would face legal sanctions for performing such a procedure. Government cannot arbitrarily inculpate the professions in such entitlement, to the detriment of their fundamental liberty and property rights to practice their profession with autonomy.

A rough analogy to the damage to nurses' autonomy under legal assisted suicide: Imagine a law granting the entitlement to assisted suicide with the help of a police officer to accomplish the killing. The damage is obvious to the ethic of police officers, whose professional responsibility is to protect innocent life. As noted above, the reason to have a professional assist is to put her imprimatur on the act.

Another analogy of damage, to another profession that might serve as provider of assisted suicide (and whose ethics much of the public already consider to be below reproach) is the legal profession. A recent article describes the perception that lawyers will do whatever their clients order, without reservations based on personal integrity or professional ethics. The authors suggest, perhaps not tongue-in-cheek, that the legal profession might be the ideal suicide assistants. R.M. Sade & M.F. Marshall, *Legistrothanatry: A new specialty for assisting in death*, 39(4) Perspectives in Biology and Medicine 547 (1996).

The American Nurses Association addresses the fine line separating the patient's autonomy from the moral mandates and integrity of his nurse:

> "Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.4.

BEING FAIR

Legal assisted suicide would damage the nursing ethic based on the value *Being Fair* (Justice), enforced by laws requiring equal treatment under the law. Other *amici* will discuss the laws that enforce fairness toward patients in this country. They include the due process and equal protection clauses of the Fifth and Fourteenth Amendments to the Constitution, the Americans with Disabilities Act, and the prohibition against discrimination toward some groups who are more likely to experience pressure to die if assisted suicide were legal.

Amici assert, as detailed above, that the fundamental fairness due nurses under the Fifth Amendment would be violated under legal assisted suicide.

BEING TRUE

Legal assisted suicide would damage the nursing ethic based on the value *Being True* (Loyalty), enforced at a minimum in law by contract law, confidentiality, informed consent, and by law requiring nurses to be advocates for patients. Nursing law mandates that nurses must be advocates for the patient, even if their action is counter to the physician or employer's order.

The changes in nursing practice that legal assisted suicide would force (elaborated above in descriptions of nurse involvement under 1.b.) are severe dislocations of the nurse's ethical and legal duties of loyalty to the patient. Under legal assisted suicide, the nurse's duty to advocate for the patient might become the duty to advocate death for the patient.

LIFE

Legal assisted suicide would damage the nursing ethic based on the value *Life*, enforced by all law that outlaws killing. Though mentioned last, this is the first value of nurses, or the one that underlies all others. The *sine qua non* of nursing ethic is promoting the life of the patient in all aspects, including the comfort of the patient and her value as

an individual. This is so, even and especially as the patient is dying. Promoting and protecting the dying patient's life cannot be subverted to mean assisting her deliberately to kill herself.

At present, the life of the individual is protected by the law, overridden only in extreme circumstances. For example, killing is justified only under narrow conditions such as self-defense, executions, or war.

Under the decisions of the Courts of Appeal, some lives would *not* be protected by law. People who are diagnosed "terminal" would not be protected from assisted suicide. But people who were not dying, *would* be protected from assisted suicide. The assumption underlying that situation: People who are not dying are more valuable than the dying.

Nurses do not discriminate in their care, between patients whose lives are less valued and more valued. This stratification of lives into levels of protection – some more valued, some less valued – is not a new concept. The framers wrote the U.S. Constitution, and courts subsequently have interpreted that Constitution, precisely to *prohibit* laws that classify lives in that way. Yet one of the decisions on review, responding to the state's contention that its principal interest is in preserving the life of all its citizens, answers:

> "[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes."

Quill v. *Vacco*, 80 F.3d at 729 (2d Cir.1996).

b. The national standard of ethics for nurses is that nurses do not assist patients to kill themselves, but threat of legal assisted suicide in one state has caused erosion of that standard.

To state the obvious: The consensus of nursing ethics is that nurses do not assist patients to kill themselves.

The maintenance of the ethical integrity of the professions involved is one of the primary interests Courts weigh in

such cases as these. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980). The court in *Superintendent of Belchertown* took care to find that its decision was in accord with the "prevailing ethical practice" of the profession. The prevailing ethical practice of the nursing profession is *not* to assist patients to deliberate death, evidenced by the following statements of ethics of American nurses.

The American Nurses Association maintains that nurses may not ethically assist suicide (as they would be asked to do under legal assisted suicide):

> "Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments. The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses With Interpretive Statements (Code for Nurses) and the ethical traditions of the profession."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.1.

The national Oncology Nurses Society endorsed the ANA position in 1995. Oncological Nurses Society, *Endorsement of ANA Position Statement on Active Euthanasia and Assisted Suicide* (1995). The American Association of Critical Care Nurses has endorsed as well.

The National Association of Prolife Nurses and its affiliates oppose assisted suicide in the strongest terms, believing it tantamount to euthanasia:

> "The public must be assured that we will not participate in euthanasia or refer people to individuals and organizations supporting euthanasia, and that we consider euthanasia to be medical murder."

Nancy Guilfoy Valko, *National Nurses Group Supports Resistance to Euthanasia*. National Association of Prolife Nurses (1994).

Though addressed to the prohibition against nurses' participation in executions, the following encompasses the ethical standard of the ANA for causing death in patients:

> "Regardless of the personal opinion of the nurse on the moral appropriateness of capital punishment, either generally or specifically, it is a breach of the ethical tradition of nursing, and its Code for Nurses, to participate in taking human life, even through a legally authorized civil or military execution."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The *amici* would add that it is a breach of the ethical tradition of nursing to participate in taking human life, even through a legally authorized nurse assisted suicide as would be possible under legal assisted suicide.

Further nurse ethical standards:

> "The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person."

American Nurses Association, *Code for Nurses* (1986).

The nurse mandate to safeguard the patient from "any person" must include physicians or other nurses who prescribe or administer drugs to cause death.

And yet another ethical standard that nurses must not aid death:

> "Nurses . . . must take all reasonable means to protect and preserve human life when there is hope of recovery or reasonable hope of benefit from life-prolonging treatment. The nurse does not deliberately act to terminate the life of any person."

American Nurses Association, *Code for Nurses with Interpretive Statements* (1986).

As noted above under 1.c., the anticipation of legal assisted suicide in Oregon has resulted in a position statement by the Oregon Nurses Association. That paper admits that nurses would have to participate or assist in their patient's suicide in several ways –

> informing patients of "choices that are legal" (as noted above, to some nurses this would be tantamount to encouraging suicide),
> "providing for ongoing end of life care" for suiciding patients if the patient couldn't be transferred (very likely if the nurse learned of the suicide attempt after the prescription were ingested), and the nurse could make no "judgmental comments or actions because of the patient's choice [to kill himself]," muzzling the nurse's ethical or professional assessment of the patient's choice.

Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995) p. 4 [Material in brackets added]. As can be seen, the threat of legal assisted suicide in Oregon resulted in a position paper from the ONA which copes with that potential reality, by lowering ethical standards to the minimum ethic: Whatever might be made legal is ethical.

In addition to the assault on their professional ethics, many nurses would have personal ethical problems in assisting suicide – though as outlined above and noted under the ONA paper, they would have little choice under legal assisted suicide. Considering the shrinking job market faced currently, nurses would be under great pressure to comply with the employer who requires them to participate with patient suicide.

Some nurses already have been disciplined with job suspension for six weeks for reporting (or for not reporting fast enough – the employer's version) an active euthanasia performed on a child by the physician. *Death at U.C. Med Center,* San Francisco Chronicle, 3 April 1995, A20; *UCSF suspends nurses who delayed reporting incident*, NURSEweek, First April 1995, 3, 20. Under legal assisted suicide, the pressure would increase on the nurse to look away from patient abuse or to lose her job.

Under legal assisted suicide nurses who are religious would face a compromise to the very fundamentals of their morality – encompassed in any version of "Thou shalt not kill." Exodus Chapter 20, Verse 13. Nurses who are not formally religious are no less spiritual, and no less harmed by such an egregious violation of their personal ethic.

Other *amici* will inform the Court of the fact that all medical associations in the world (save Holland's) oppose assisted suicide. They will describe the experience in Holland in which even the tacit legal approval of euthanasia and assisted suicide – far short of the outright legal assisted suicide as proposed by the Courts of Appeal – has become a large problem, for the society, the professions, and most of all the patients of that country.

3. Legal assisted suicide would inculpate nurses in assisting suicide, damaging the profession in the eyes of the public.

a. Under legal assisted suicide, some nurses *would* assist in patient killing.

No illusions may be indulged; under legal assisted suicide, some nurses would be ready, willing and able to assist suicide. Some would kill patients directly if assisted suicide were extended to the disabled who are unable to self-administer the drugs.

The experience of nurses in the 1930's under Germany's National Socialism is instructive. Though some would wish it not so, 1990's American nurses too would be vulnerable to pressures if killing were made legal. Under National Socialism, some nurses and their associations collaborated when Hitler's euthanasia program was legal.

Some German nurses deliberately administered barbiturates to mentally retarded children that they had selected; the children slept for long periods, developed pneumonia as a result, and died a "natural" death. The death certificates read "Pneumonia," but in the consensus of world opinion, ten and now fifty years after, those nurses caused the deaths of those children. *Testimony of Dr. Valentin Falthauser, 22-23 April 1948; and Nurse Mina Worle, 7 May 1948 (Kaufbeuren asylum)*, Heyde Trial, pp. 143-47, in Robert Jay Lifton, *The Nazi Doctors* (1986) p.55.

The nurse associations of Germany collaborated in changing the ethics of the profession to conform to the legal mandates of the National Socialist government. Hilde Steppe,

Nursing in Nazi Germany 14(6) West. J. Nurs. Res. 744 (1992). Some nurses were not, would not be, immune to pressures to eliminate the problem patient instead of eliminating the patient's problem.

b. If legal, future killing would be delegated to nurses.

In addition to the immediate consequences of legal assisted suicide to the profession, the *amici* have reason to worry about their even worse role in the future. Under legal assisted suicide *amici* believe assisted suicide would be extended to actual administration of "suicide" to the disabled and incompetent. Allowing only competent able patients to kill themselves with prescribed drugs inevitably would be held to discriminate against the disabled who can't self-administer the drugs, and against the incompetent who can't request the killing drugs. At that point, prescribing suicide or even direct euthanasia would fall to the nurses as does other dirty work.

In support of that prediction: Technical procedures always are delegated eventually. When blood pressure measurements were first available, only doctors were allowed to perform them. At present, the *amici* are confident that few members of the Court have ever had their blood pressure measured personally by a doctor. When first developed, the technology of intravenous medication was limited to doctors (as late as the 1970s it was not taught in nursing curricula), as was administration of chemotherapy, and virtually all intensive care technology, including interpretation of electrocardiograms.

Today, in various states, nurses can perform all those procedures; in addition, nurse practitioners may set broken bones, suture wounds, and prescribe almost all drugs that physicians can. Under legal assisted suicide, it would be a short matter of time before this last worst "technique" of assisting suicide would be delegated to the nurse.

c. Allowing nurses legally to assist suicide would result in deterioration of the public's trust in their profession.

The public's perception of nurses would change under legal assisted suicide as nurses came to be seen as people who assist with killing. The public would lose confidence in nurses, and would be suspicious of the nurse's intent when she nursed patients labeled "terminal." The social contract that nurses have with the public would be breached. The ANA believes that trust to be essential:

> "Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life. The profession's covenant is to respect and protect human life (Nursing: A Social Policy Statement). Nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession."

Position Statement on Assisted Suicide, p.4.

Assisting in deliberate killing of patients, either by prescribing self-administered medications (nurse practitioners), or by tacitly approving of the patient's decision to die by participating in their care as they suicide – would violate the nurses' social contract with their patients and result in the public's loss of trust in the profession.

If nurses could assist suicide legally, the public's perception of nurses would change. Nurses who could assist in suicide would be seen not as trusted advocates but as people who carry out orders regardless of their effect. They would not be seen as professionals with autonomy and independent judgment, but as lackeys who do the patient's or doctor's bidding no matter how heinous the morality of the order.

Patients would not trust nurses who were handmaidens to physicians prescribing death, and who were unquestioning, "nonjudgmental" servants to any patient with a prescription. At present, the wish to die to the nurse is a cry to help the patient to find reason to live. Under legal assisted suicide, it

would be a mandate to nurse the patient to deliberate death. The public's opinion of nurses could not help but decay.

The nurse's liberty to practice nursing as she knew it and chose it and learned it would be curtailed. Her property interest in working at her profession would deteriorate. Hers then would be a profession with an ethic of promoting or assisting patients to deliberate death, instead of to life.

CONCLUSION

Legal assisted suicide creates an entitlement to assistance with, and approval of, suicide. It inevitably will inculpate nurses in the killing of their patients. It would destroy the public's confidence in the profession of nursing, damaging the nurses' liberty and property rights to practice that profession. It purports to help patients who either do not wish to die (terminal patients, even those in pain) or who are treatable and would be treated if society valued their lives (terminal patients who are depressed and ambivalent). That unwanted, unneeded entitlement is granted to the awful detriment to the fundamental rights of nurses who wish to practice their profession uncorrupted.

Based upon the above, the decisions of the Courts of Appeal should be reversed and the cases remanded for disposition in accordance.

Respectfully submitted,

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November 8, 1996 *Attorney for Amici Curiae*

APPENDIX

Statements of Interest

This brief *amici curiae* is submitted to the Court by people who will be uniquely and directly affected by the Court's decision in this case. *Amici Curiae* are:

The National Association of Prolife Nurses, nurses who promote and protect the lives of patients at all stages of life, was formed in 1973 with state affiliates and members in all states. Their activities on behalf of patients, and on behalf of nurses who protect patient lives, include legal representation, education, and organization. The members have supported an *amicus* brief to the Ninth Circuit in the case challenging the legalization of assisted suicide in Oregon still pending there.

The National Association of Directors of Nursing Administration in Long Term Care, the managers of facilities where some patients are cared for who would be subject to assisted suicide if legal, was formed in 1986, and has 30 state affiliates with 4000 members from all states. Their code of ethics mandates they support and promote quality of care for those individuals receiving long term care, and concern for those delivering long term care.

The Philippine Nurses Association of America, nurses of Philippine ethnicity who live and work in the U.S., was formed in 1979, and has 25 state affiliates with over 2000 individual members. Their endorsement of the Code of Ethics of the International Council of Nurses mandates they protect, promote and restore health when possible, prevent illness when possible, and alleviate suffering; thus

they believe the legalization of nurse assisted suicide and euthanasia will change the very essence of nursing practice.

The Scholl Institute of Bioethics, a group of professionals in medicine, law, psychology and religon, was established in 1986 because of concern for the increasing difficulty of bioethical decisions that both individuals and the medical profession are facing in relationship to today's modern advances in medicine and the growing euthanasia movement.

California Nurses for Ethical Standards, a non-profit educational and professional organization of nurses who promote in all respects ethical standards of health care, was established ten years ago in the state of California. The members believe that euthanasia and assisted suicide violate all nursing ethics codes.

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Nos. 95-1858 and 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*, *Petitioners*,

v.

TIMOTHY E. QUILL, *et al.*, *Respondents*.

WASHINGTON, *et al.*, *Petitioners*,

v.

HAROLD GLUCKSBERG, *et al.*, *Respondents*.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF OF AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, *ET AL.*,* AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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34 pp

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Alabama Association of Homes & Services for the Aging
Arizona Association of Homes & Services for the Aging
Association of Ohio Philanthropic Homes, Housing and Services for the Aging
Connecticut Association of Homes & Services for the Aging
Delaware Association of Homes & Services for the Aging
Iowa Association of Homes & Services for the Aging
Life Services Network of Illinois
Louisiana Association of Homes & Services for the Aging
Oklahoma Association of Homes & Services for the Aging
Oregon Alliance of Senior & Health Services
Rhode Island Association of Facilities & Services for the Aging
Tennessee Association of Homes & Services for the Aging
Wisconsin Association of Homes and Services for the Aging

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INTEREST OF AMICI

The American Association of Homes and Services for the Aging (AAHSA), and its related state associations are national and state nonprofit membership associations that together represent over 5,000 not-for-profit facilities and organizations providing housing, health care, and other services to more than 1,000,000 aging and disabled individuals. Seventy percent of AAHSA homes and organizations have religious sponsors, which include Catholic, Protestant, Jewish, and Muslim denominations. Others are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups.

Many of AAHSA's members are nursing homes. Both its nursing home members and most other members also provide community-based services such as home health care, hospice care for those in the last stages of terminal illness, and specialty care for those with Alzheimer's disease and other forms of dementia. Other members provide housing for low- or moderate-income seniors, often with supportive services (*e.g.*, periodic routine tasks) or more intensive home-based services. Approximately 700 AAHSA members are continuing care retirement communities, which provide "continuum of care" health care and housing on one site for the remainder of their residents' lives: residents maintain independence in their own homes for as long as possible by using home-based services, but they receive skilled nursing home care if needed.

This case is of extraordinary importance to all Americans. It will affect how millions of people view and treat the end of their lives. It may fundamentally alter the

relationship between patient and physician or other caregiver. And it may erode this nation's long-held convictions about the intrinsic value of all human life.

In particular, though, the Court's decision will directly and practically affect all of AAHSA's 5,000 members. AAHSA members' mission is to provide both quality care and a high quality of life for people at the end of their lives. Their residents and clients increasingly choose to die outside a hospital—in an AAHSA member nursing home, housing facility, community care retirement community, or in their private home while receiving AAHSA member services. Most of the individuals they serve are seniors; many are frail and in the last stages of their lives. These individuals are among society's most vulnerable populations. Because such patients will become terminally ill or die while in their care, AAHSA's facilities and service organizations are among the few structures in American society that deal with death, and must directly confront end-of-life issues, on a daily basis.

Based on a report by the AAHSA Commission on Ethics in Long Term Care, and by resolution of its Board of Directors, AAHSA has declared that "all persons are sacred regardless of their physical or mental condition" and that it is "opposed to a physician or other person assisting another in the taking of their own life." App. 1a. Like the American Medical Association, AAHSA distinguishes between physician-assisted suicide and both the withdrawal of life support and the prescription of pain therapy that has an expected but unintended consequence of shortening life; "intention is important," and society has long recognized that the right to be free of bodily contact and to let nature take its course includes a right to refuse medical treatment. *Id.*

AAHSA fears that a decision by this Court establishing an overarching right to physician-assisted suicide would profoundly harm the lives of its members' 1,000,000 residents and clients. Many AAHSA members would undoubtedly exercise their right of conscience and refuse to participate in assisted suicides. But that would not eliminate such a decision's harm. Striking down dozens of State laws against assisted suicide would create a risk, which no regulatory safeguards could eliminate, of decisions for death that are made while a person is clinically depressed, incompetent, or overly vulnerable to coercion by others and by societal expectations. And it would inexorably move homes and services for the aging away from a culture of life, caring, and trust towards a culture of death and distrust.

SUMMARY OF ARGUMENT

The opinions of the Ninth and Second Circuits mistook the exception for the rule. Only in exceptional circumstances may judges countermand the majority's will as expressed through a democracy. Only in exceptional cases may judges take it upon themselves to solve complex and controversial societal problems—in essence, political questions. Especially when the governing political body is a State and the court is federal, *see Gregory v. Ashcroft*, 501 U.S. 452, 457-59 (1991), the exception must be well grounded in the Constitution and in this Court's jurisprudence. No such exception applies here.

There is no fundamental right to receive assistance in committing suicide. Our Constitution and history not only fail to support such a notion; they flatly contradict it. Nor can any right be deemed nonfundamental but

nevertheless of enough constitutional significance to require a "balancing of interests" or any other form of heightened scrutiny. History and the Court's unbroken precedent contradict even this more limited holding. What is worse, such a holding only *appears* more limited; it would necessarily free courts to balance away any number of State interests in favor of any number of hitherto unrecognized rights. The Ninth and Second Circuit decisions do not merely create this slippery slope; they themselves proceed well down the slope.

Even if there were a right to assisted suicide (fundamental or otherwise), it would give way to compelling State interests. The first is the most compelling interest of all, that of protecting human life. This Court and others have already recognized that a State may assert an interest in protecting *all* human life, without devaluing a particular person's life based on his physical or mental condition. As a corollary, the State has a compelling interest in protecting the lives of individuals who do not make competent or truly voluntary decisions to commit suicide. Even physician-assisted suicide's strongest proponents acknowledge as much. But they fail to acknowledge the experience of AAHSA's members and other health care providers showing that competency and voluntariness are so fluid, complex, and subjective, and terminally-ill patients so vulnerable to pressure, that nothing short of a prohibition on assisted suicide will serve the State's interest. Finally, the State has a compelling interest in maintaining the relationship of trust between organizations that serve the aging and their clients, as well as between physicians and patients. Physician-assisted suicide would poison that relationship

and create fundamental conflict with AAHSA members' missions.

Once the due process question is answered, the equal protection analysis should follow *a fortiori*. Once the distinction between the generally accepted right to refuse life-sustaining treatment and the claimed right to assisted suicide is determined to be constitutionally significant under the Due Process Clause, it is unquestionably rational under the Equal Protection Clause. The distinction also has long been recognized by AAHSA members, physicians, ethicists, legal societies, courts, and democratic majorities. For the Second Circuit to declare all these thinkers' conclusions *irrational*, and for it to miss the glaring inconsistency between its due process and equal protection holdings, reveals the decision for what it is: a novel substantive due process holding in disguise.

ARGUMENT

I. THERE IS NO FUNDAMENTAL RIGHT TO ASSISTED SUICIDE, AND THAT CONCLUSION SHOULD END THE INQUIRY.

The primary issue in this case is whether the Federal Constitution confers any right to receive assistance in committing suicide notwithstanding the laws of the many States that still make such conduct illegal and have done so for a very long time. No such right exists, and this Court can create one only if it jettisons firmly-established and unquestioned precedent on identifying which interests receive any sort of heightened protection under the Due Process Clause. Neither *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261

(1990), nor *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), strayed from that precedent, and the Court should not do so now.

Even the Ninth Circuit labeled "not controversial" the Court's description in *Bowers v. Hardwick*, 478 U.S. 186 (1986), of what liberty interests are deemed fundamental. *Compassion* Pet. App. 31a n.16.[1] An interest "not readily identifiable in the Constitution's text" must be " 'implicit in the concept of ordered liberty,' " or, stated differently, " 'deeply rooted in this Nation's history and tradition.' " 478 U.S. at 191-92 (citations omitted). This formulation has a very long pedigree, *see, e.g.*, *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (referring to a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental"), which continues to this day, *see, e.g.*, *Reno v. Flores*, 507 U.S. 292, 301-02 (1993).

Even the Ninth Circuit did not venture to say that a fundamental right to suicide can exist under this standard. Not only is such a right not "rooted in the traditions and conscience of our people," *Snyder*, 291 U.S. at 105, but as numerous academic articles, court decisions, and now briefs to this court detail, both suicide and assisting suicide were widely considered criminal offenses for centuries; states largely decriminalized suicide for reasons other than changed attitudes about its morality, and a large majority of states still make assisting a suicide a felony. *See especially* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1985).

[1] The Ninth Circuit opinions as appended to the Petition for Writ of Certiorari in *Washington v. Glucksberg* are cited as "*Compassion* Pet. App. __." The Second Circuit opinion as appended to the Petition for Writ of Certiorari in *Vacco v. Quill* is cited as "*Quill* Pet. App. __."

Instead, the Ninth Circuit created out of whole cloth a new substantive due process doctrine designed to subvert the purpose behind limiting the range of interests deemed fundamental. According to the court, the identification of a nonfundamental liberty interest unleashes a "balancing test" that still "requires the state to overcome a substantial hurdle in justifying any significant impairment." *Compassion* Pet. App. 33a. The only support the court enlisted for its test was *Cruzan* and the earlier cases recognizing an interest in refusing medical treatment. But those cases cannot honestly be read to treat that liberty interest as anything other than fundamental.[2]

Other decisions directly contradict the Ninth Circuit's imagined framework. Nearly every decision declining to find a fundamental liberty interest simply ends its analysis without performing any scrutiny of the statute. *See, e.g.*, *Bowers*, 478 U.S. at 196 (brushing aside respondent's "assert[ion] that there must be a rational basis for the law and that there is none in this case"). The most this Court has ever suggested is that, if a liberty interest

[2] *See Cruzan*, 497 U.S. at 269 (" 'No right is held more sacred, or is more carefully guarded, at common law . . . .' " (citation omitted)); *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982) (resting on a " 'historic liberty interest' " and an interest "recognized as the core of the liberty protected by the Due Process Clause"); *Mills v. Rogers*, 457 U.S. 291, 301 (1982) ("[T]his interest of the individual is of such importance that it can be overcome only by 'an overwhelming State interest.' " (citation omitted)).

exists that is not fundamental, a law need only be "rationally connected to a government interest." *Reno*, 507 U.S. at 303.

This Court should not follow the Ninth Circuit's attempted lead in creating a balancing test for non-fundamental rights. The Court has limited the list of fundamental rights because "[t]he doctrine of judicial self-restraint requires [it] to exercise the utmost care whenever [it is] asked to break new ground in this field." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Such a balancing test could be applied to an endless list of newly-found interests that could never be deemed fundamental. Courts could then use the test—as the Ninth Circuit did here—to elevate an interest to fundamental status in all but name and to run roughshod over legitimate State interests by denigrating their importance. *Compassion* Pet. App. 63a-114a. Accepting the balancing test would give courts license to sidestep the "guideposts for responsible decisionmaking in this uncharted area." *Collins*, 503 U.S. at 125.

Cruzan provides no more support for substantively inferring a right to suicide than it does for creating a new framework for inquiry. The right against physical invasion of bodily integrity, on which *Cruzan* squarely rested its recognition of an interest in refusing treatment, *see* 497 U.S. at 269, simply does not apply to a desire to kill one's self by ingesting death-inducing drugs.

Planned Parenthood v. Casey and its predecessors are also not helpful, let alone "prescriptive," *Compassion* Pet. App. 57a, in inferring a right to suicide. The Court has disclaimed the Due Process Clause as a basis for a woman's interest in terminating her pregnancy. The

three Justices announcing the Court's judgment in *Casey* upheld *Roe v. Wade*'s finding of a liberty interest based on a concern for *stare decisis* principles and the Court's legitimacy, "whatever degree of personal reluctance any of us may have" for doing so. *Casey*, 505 U.S. at 854-69; *see also id.* at 871. Four more Justices voted to overrule *Roe*. *See id.* at 944-66 (Rehnquist, C.J., concurring in part and dissenting in part). If the Court today would not on a clean slate find a new fundamental liberty interest in choosing to terminate a pregnancy, it would be quite peculiar to hold that the reproductive choice decisions compelled the Court to find an entirely different new fundamental liberty interest.

Even if used to discern a different liberty interest, the reproductive choice decisions provide little guidance here. The Court has recognized that "abortion is a unique act" and that with pregnancy "the liberty interest of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. Abortion involves ending what the Court has necessarily deemed only "potential life," *id.* at 870, not the fully realized life of a person seeking suicide.

Both the Ninth and Second Circuits rested their decisions on *Casey*'s dicta describing prior privacy decisions as "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy," and "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.* at 851. But *Casey* used that passage to frame its explanation that abortion involves more than "beliefs about these matters"; it is

"conduct" that is "fraught with consequences for others." *Id.* at 851-52.[3]

The lower courts lifted the *Casey* passage out of context and used it as an engine that can mint a practically unlimited number of new fundamental constitutional rights that contradict long-held societal consensus. For "[i]f physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and indeed, the use of illicit drugs?" *Compassion* Pet. App. 10c (O'Scannlain, J., dissenting from denial of rehearing en banc by the full court). Especially in light of the *Casey* opinion's true holdings, this passage cannot be read to overturn decades of constitutional jurisprudence intended to limit courts' temptation to substitute their judgment for that of democratic majorities. This Court should take the opportunity to foreclose such a use of *Casey* by lower courts in the future.

II. THE STATES' COMPELLING INTEREST IN PROTECTING HUMAN LIFE OUTWEIGHS ANY RIGHT TO ASSISTED SUICIDE.

Petitioners and other *amici* raise several compelling state interests that prohibitions on assisting suicides promote. AAHSA focuses on three: the interest in protecting the sanctity of all human life, the interest in preventing suicides that are not truly made voluntarily by mentally competent patients, and a corresponding interest in pre-

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[3] The Court's list of individuals bearing those consequences, *see id.*, applies with full force to the act of committing assisted suicide.

serving the trust the disabled and aging place in long-term care institutions such as AAHSA's members. A prohibition on physician-assisted suicide is necessary to preserve all human life, to protect against less-than-voluntary deaths, and to ensure that long-term care facilities and services for the aging do not become centers of death and suspicion.

A. Protecting the Sanctity of All Human Life is the Most Compelling of All State Interests.

The Due Process Clause itself lists life as the first interest worthy of its protection. Prohibitions on suicide reveal that society has long recognized that the State's interest in preserving life can outweigh the individual's desire to die. Nor does the quality of the individual's life eliminate the State's interest; prohibitions on suicide or assisting suicide have never made an exception for terminal illness. *See Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citing several cases and other authorities). Apart from the Ninth Circuit, courts and other thinkers throughout time have recognized that "it would violate the concept of human dignity to measure the value of a person's life by that person's physical and mental condition." *People v. Kevorkian*, 527 N.W.2d 714, 727-28 n.41. (Mich. 1994). Thus the Court in *Cruzan* held that, even when a patient is in a persistent vegetative state, "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." 497 U.S. at 282.

Here, too, the State may assert an unqualified interest in preserving all human life, including that of terminally

ill patients. The Ninth Circuit's attempt to diminish that interest to near-nothing based on its cavalier judgment that the terminally ill patient's life is not worth protecting, *Compassion* Pet. App. 63a-101a, runs counter to *Cruzan* and to an unbroken consensus throughout history.

The Court's reproductive choice precedent firmly supports the State at this point in the analysis. A central principle of cases from *Roe* to *Casey* is that the State's " 'important and legitimate interest in potential life' " becomes paramount upon viability. *Id.* at 871 (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)). Even a terminally ill patient is a viable human life. *Cf. Compassion* Pet. App. 146a (Beezer, J., dissenting) (distinguishing between a patient seeking assisted suicide and a patient on life support by categorizing them as essentially viable and nonviable). The same decisions also acknowledge the State's " 'important and legitimate interest in protecting the health of the pregnant woman,' " notwithstanding the burdens State restrictions place on that very same woman's liberty interest. *Casey*, 505 U.S. at 875-76 (quoting *Roe*, 410 U.S. at 162).

Nothing short of a prohibition on ending a life will further the State's interest in protecting that life. Thus the reproductive choice decisions allow the State to prohibit abortions of viable fetuses. *Casey*, 505 U.S. at 879 (quoting *Roe*, 410 U.S. at 164-65). As in those cases, the State's interest in protecting a viable human life outweighs a burden on any liberty interest a terminally ill person arguably has in assistance to suicide.

B. States Cannot Practicably Limit Physician-Assisted Suicide Only to Mentally Competent Patients Making Voluntary Decisions.

Cruzan held that Missouri's compelling interest in preserving even vegetative human life outweighed a patient's interest in refusing medical treatment because it helped prevent "an erroneous decision to withdraw life-sustaining treatment," which "is not susceptible of correction." 497 U.S. at 283. Here, as in *Cruzan*, a serious risk of irreversible error exists—a risk that a patient's decision to commit suicide will not be made while he is sufficiently competent or will not be truly voluntary.

The Ninth Circuit cavalierly brushed aside these risks by making the naked assumption "that sufficient protections can and will be developed" to "ensure that the possibility of error will be remote." *Compassion* Pet. App. 103a-104a. The individuals who comprised the New York State Task Force on Life and the Law, with far more relevant experience than federal judges, found such a faith in safeguards "naive and unsupportable." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994). AAHSA members' actual experience with terminally ill residents is similar.

Paradoxically, the same terminal illnesses that place a person within the lower courts' newly-"protected" class often cause clinical depression, neurological dysfunction, and corresponding competency questions. And no question exists that these ailments affect a person's decision to live or die: "patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.* at 13 (footnote omitted). Indeed, 95 percent of

all suicides "have a diagnosable mental disorder at the time of death." *Id.* at 11.

The proper response to a mental ailment is to treat it, not surrender to it. Treatment for clinical depression in particular can produce a complete recovery. Many people who initially express a desire to take their lives later regain their mental balance and regain a sense that their lives are worth living. Even sufferers of Alzheimer's disease, who over the long term face irreversible mental decline, experience day-to-day ebbs and flows in their lucidity.

All agree that a decision to take one's life should not be made while incompetent or clinically depressed. But merely imposing competency requirements on assisted suicide decisions cannot prevent such errors. Both competency and depression exist along subtle continuums that are not susceptible to precise measurement. Individuals can suffer a range from mild depression to psychotic depression; indeed, the same individual may slide from one to the other, with a correlating shift in their competency. And competency is a multifactorial concept; persons can be disabled in some cognitive areas and not others.

Almost all residents of AAHSA members experience what is called "aging in place": they begin their stays competent but *gradually* slide toward incompetency. Many, if not most, reach the point at which they are deemed incompetent before passing away or leaving the facility. At any given time, a facility's staff can identify some residents that are still clearly competent and some that are clearly not, but the majority falls somewhere in the undefined middle.

Competency determinations are problematic in and of themselves. They depend on interview measurements that are highly subjective and highly variable across interviewers. Psychological examination is also particularly susceptible to a diagnosis that merely confirms the examiner's pre-interview expectations. If diagnoses are made by physicians without advanced psychiatric training, the examiner is even more likely to overlook some mental illnesses or other competency factors. A physician also may base a determination on very infrequent contact with the individual; residents receive their daily care from nurses, and physicians may see them as little as once per month.

The risk that this sea of complex subjectivity may obscure the decision to die of a mentally incompetent person—a person who might regain his mental equilibrium and later choose to live—is a compelling reason for a State to enforce a prophylactic rule.

Equally compelling is the terminally ill's extraordinary vulnerability to the overt suggestions of others, to psychological pressure, or to perceived societal expectations that they take their own lives. Here, too, no regulation can assure that such pressures have not caused a less-than-willing suicide.

Terminally ill individuals are often disconcerted, preoccupied, emotionally unsettled, and fully confronting their existence and their mortality for the first time. They are seeking aid and answers from those around them. They are, almost by definition, physically frail—often severely fatigued, in pain, and having trouble performing simple tasks such as breathing, eating, and relieving themselves. They may experience depression or

other mental deficits that do not raise serious competency questions but nonetheless further reduce the independence of their decisionmaking.

Such vulnerable individuals may face pressure to take their lives from several sources. One is the physician herself. The original three-judge panel was correct that "[p]hysician neutrality and patient autonomy, independent of their physician's advice, are largely myths. Most patients do what doctors recommend." *Compassion* Pet. App. 15d. Another source is the individual's family. A family's suggestion may be spurred by a selfish desire to lift the financial and emotional burden of caring for the terminally ill,[4] or merely by an honest belief, not otherwise shared by the individual, that a faster death is better for him.

A third source is society as a whole. Even in the absence of overt or subtle suggestion by medical personnel or family members that taking one's life is "the right thing to do"—even in the presence of statements reassuring the patient that the choice is his—he may feel an unwanted obligation to unburden his family and society of himself. Our choices, even our most important and personal ones, are constrained by accepted norms. We

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[4] Terminally ill patients typically have very high medical costs. Medicare payments provide one indicator: In recent years, expenses for patients in the last year of their lives have accounted for between 27.2 percent and 30.6 percent of all such payments. *See* James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 New Eng. J. Med. 1092 (1993). Society may reasonably consider whether this is the best possible allocation of either public or private resources, but it should not reallocate them by pushing the elderly to kill themselves.

largely do what is expected of us, and the terminally ill may see taking their own lives as expected of them.

Indeed, the very act of constitutionalizing a right to suicide would alter attitudes about what society *expects* of individuals, not just what it *permits*. If this Court affirms the judgments below, physician assisted suicide will be more than an option; the nation's highest court will have declared it a constitutional right of enough weight to overcome the informed judgments of numerous democratic majorities and several admittedly compelling State interests. As one facility staff member has written in correspondence to AAHSA, residents

> may use such an assumption [that there is a Constitutional right to assisted suicide] as a further endorsement that the community also does not believe they have the right to continue to live.

The opinion for the Court in *Casey* relied explicitly on its recognition that the Court's earlier reproductive choice decisions have had such an effect. *See* 505 U.S. at 856 (noting that people have relied on *Roe* to "ma[k]e choices that define their views of themselves and their places in society" and "have ordered their thinking and living around that case"). This Court should not spur society to downgrade the value it places on human life and, by so doing, cause vulnerable, terminally-ill patients to "choose" suicide when they otherwise would not have done so.

One final barrier to true safeguards ensuring voluntariness springs from the intersection of the competency and coercion questions. Because competency determinations are highly subjective, a physician's belief that suicide is the better choice may either color her determi-

nation in favor of finding competency or, in the worst case, provide cover for her decision to act "paternally." Even if regulations require a second opinion, the reality of medical practice is that a physician's colleagues are unlikely to challenge her determination in close cases—especially if she has a hand in selecting the colleague. This level of subjectivity is simply not prone to effective regulation.

The same concerns that are present here—a vulnerable population and subjective, unpolicable questions of voluntariness and competency—have supported prophylactic rules against statutory rape, even though some minors can make competent, voluntary decisions to engage in sex with an adult. This Court should not dismiss such concerns in the context of physician-assisted suicide. Error here leads to an unquestionably wrongful taking of a human life, and lowering that risk is the most compelling of all State interests.

C. Physician-Assisted Suicide Will Undermine the Trust that the Elderly and Their Families Must Have in Institutions and Organizations Serving Them.

AAHSA's members and other providers of care and services to the aging are dedicated to the preservation and enhancement of each client's life and quality of life. This dedication is reflected in their respective charitable missions and in the care and compassion they show to all whom they serve, particularly the most vulnerable—the frail and infirm elderly who face end-of-life decisions. Congress also has not only acknowledged but mandated

this purpose for Medicare and Medicaid providers.[5] The statutes explicitly place the interest in residents' health and safety above some of their own wishes.[6]

The potential for physician assisted suicide would fundamentally alter the relationship between the aging and the organizations that serve them.[7] If prohibitions on assisted suicide are struck down, these institutions could be asked—and perhaps required—to be the agents of their clients' deaths rather than the protector and enricher of their lives. Such an obligation would conflict irreconcilably with the mission of many AAHSA members, both those that are religiously sponsored and those

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[5] *See, e.g.*, 42 U.S.C. §§ 1395i-3(b)(1)(A), 1396r(b)(1)(A) (requiring a facility to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident"); *id.* §§ 1395i-3(b)(2), 1396r(b)(2) (requiring a facility to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, in accordance with a written plan of care" for each resident).

[6] *See, e.g.*, *id.* §§ 1395i-3(c)(1)(v), 1396r(c)(1)(v) (residents have the right to "reasonable accommodation of individual needs and preferences, except when the health or safety of the individual . . . would be endangered").

[7] Assisted suicide creates an unquestioned conflict with specific norms and rules within facilities for the aging; the very act that may be deemed a constitutional right is otherwise specifically forbidden by regulation. *See, e.g.*, 42 C.F.R. 483.25(l) ("Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose . . . (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued . . . .").

that are not.[8] AAHSA has received many letters from staff at member facilities expressing this view. As one wrote:

> If within our settings suicide is an abetted activity in response to the client's frustration, it can unwittingly become an encouraged activity in response to the agency's frustration. . . . I am unalterably opposed to undermining our few remaining pockets of caring culture by turning them into places of purposeful killing.

Many medical ethicists have written that introducing physician-assisted suicide into the physician-patient relationship will seriously undermine patients' trust that physicians are committed to preserving life, which is at the core of the relationship. *See, e.g., Decisions Near the End of Life*, 267 J. Am. Med. Ass'n 2229, 2232 (1992); *cf.* American Medical Association *Code of Ethics* § 2.211 (concluding that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer"). This breakdown of trust has even more drastic effects on the relationship between AAHSA members and the people they serve.

Unlike the selection of a doctor, the choice to enter a nursing home or other facility for the aging entails a fundamental life shift—uprooting one's home and placing large areas of one's life into the hands of others. Many seniors choose to make this move even when their physical state does not make it necessary because they view it as beneficial; they can trust in a facility's mission of preserving life and health when they entrust their lives to it.

One of this nation's most vulnerable populations relies on AAHSA members to show a compassionate commitment to life at one of its most trying yet precious moments. Especially if residents fear that the choice will be subtly forced upon them, physician-assisted suicide will threaten this relationship and poison the environment in which long-term care and services are provided, to the detriment of both caregiver and recipient. Some caregivers' refusal to participate in assisted suicide would not

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[8] Although the invalidation of statutes *prohibiting* assisted suicide would not *require* facilities to engage in such practices, states may move in that direction in response to this Court's decision. And although religiously-sponsored organizations have a constitutionally protected right to refrain from practices such as assisted suicide that violate their religious principles, the right does not extend to AAHSA members who are not religiously sponsored and who hold the same views on secular grounds.

Even for religiously-sponsored members, the right is not absolute. *Compare Employment Division v. Smith*, 494 U.S. 872 (1990) (finding no Free Exercise Clause violation of generally applicable governmental regulation of conduct) *with* Religious Freedom Restoration Act of 1993, 42 U.S.C. § 2000bb(b)(1) (requiring a compelling interest for regulations that burden religious exercise). If this Court finds a constitutional right to assisted suicide and a state attempts to require facilities to assist, advocates and perhaps courts will use the Court's finding here to argue that the State has a compelling interest in furthering the constitutional right. *Cf. Swanner v. Anchorage Equal Rights Comm'n*, 874 P.2d 274, 279-284 (Alaska) (finding that a compelling interest in preventing marital status discrimination outweighed the defendant's free exercise rights even though marital status has never received heightened constitutional protection), *cert. denied*, 115 S. Ct. 460, 460-62 (1994) (Thomas, J., dissenting from denial of certiorari) (noting the conflict among the courts on this issue).

If this Court finds some right to assisted suicide, it should at the least make clear that organizations serving the aging have a right of conscience to refuse to assist.

prevent the degradation of trust for the profession and aging community as a whole. One facility's staff member put it succinctly in a letter to AAHSA.

> Many of [the people we serve] believe if they enter a nursing home they will not receive compassionate and quality care. Why would we want to add another fear—the fear that we might take their lives?

There is no doubt that the State has a compelling interest in mitigating this fear.

III. STATES MAY RATIONALLY DISTINGUISH BETWEEN A DECISION TO DECLINE LIFE-SUSTAINING TREATMENT AND ONE TO COMMIT SUICIDE.

The Equal Protection Clause "simply keeps governmental decisionmakers from treating differently persons who are *in all relevant respects* alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992) (emphasis added). This Court has stated many times, in many different ways, the extreme deference courts must pay to the State's determination of what is relevant for line-drawing purposes. A distinction is rational "if there is any reasonably conceivable state of facts that could provide a rational basis"; when there are " 'plausible reasons' " for the State action, " 'our inquiry is at an end.' " *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-16 (1993) (collecting cases; citation omitted); *accord Gregory v. Ashcroft*, 501 U.S. 452, 473 (1991).

In finding an Equal Protection Clause violation, the Second Circuit restated the bare-bones rational basis test but conspicuously omitted mention of the deference due

the State in determining what is rational. *Quill* Pet. App. 21a-23a. Even a cursory examination of the classification at issue confirms that, when such deference is given, prohibitions on physician-assisted suicide must be found constitutional.

The Second Circuit examined state laws that apply equally to all citizens, apart from one small group (people who require life-sustaining treatment). It then performed its own exquisite line-drawing to create a new small group with different, ill-defined, and in some cases unidentifiable characteristics ("mentally competent patients who seek to end their lives during the final stages of a terminal illness" through "prescribe[d] drugs to be self-administered"). *Quill* Pet. App. 4a. The two groups are not coextensive: not all patients who need life-sustaining treatment are terminally ill, *see, e.g.*, *Cruzan*, 497 U.S. at 266-67, and not all terminally ill patients need life-sustaining treatment. Incredibly, the Second Circuit concluded that the Equal Protection Clause *requires* the State to lift the court's newly-created group out of the general citizenry protected by laws against assisted suicide and place them in the small category currently occupied only by patients needing life-sustaining treatment.

Two rational bases exist for distinguishing between the two groups of patients. One is the age-old common law right to maintain one's bodily integrity, as explained so forcefully in *Cruzan*, *see* 497 U.S. at 269; that right comes into play only for patients needing medical treatment to survive. The other is the distinction between affirmatively employing medical science to shorten a patient's life and letting nature, in the form of some otherwise-fatal affliction, take its course. Although these

are thin lines, *see Cruzan*, 497 U.S. at 295-98 (Scalia, J., concurring), they are lines that have been drawn throughout much of history and are drawn today—by AAHSA,[9] by physicians (including groups submitting *amicus* briefs in this case),[10] by academic ethicists, by legal groups such as the American Bar Association,[11] by courts[12] (including this one),[13] by carefully selected interdisciplinary task forces,[14] and by democratic majorities that have criminalized one but not the other.[15]

For three or eight federal judges to declare this overwhelming weight of authority from many segments of society *irrational* is a breathtaking exercise of judicial hubris.

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[9] App. 1a-2a.

[10] *See, e.g.*, American Medical Association, Council on Ethical and Judicial Affairs, *Physician Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 92 (1994).

[11] American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (1992).

[12] *See Compassion* Pet. App. 10c n.12 (citing court decisions). Judge Kleinfeld's analogy to General Eisenhower's decision to launch the Normandy invasion is a powerful dissection of the Ninth Circuit majority opinion's confusion on this issue. *Compassion* Pet. App. 163a (Kleinfeld, J., dissenting).

[13] While assuming a right to refuse treatment, *Cruzan* also noted the many laws criminalizing assisted suicide. *See* 497 U.S. at 279-80.

[14] *See* New York State Task Force, *supra*, at viii, 71.

[15] *See* Thomas J. Marzen, *"Out, Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 806 n.25 (1994) (citing statutes of forty states).

It is even more breathtaking when one realizes that the Second Circuit had already found the distinction to be *constitutionally mandated* under the Due Process Clause. One reaches the Equal Protection Clause issue at all only by first concluding, as the Second Circuit correctly did, that refusing life-sustaining treatment and ingesting poison are different enough to mandate a fundamental liberty interest in one but not the other. The Second Circuit's studied indifference to this glaring inconsistency, coupled with its peculiar balancing of State and liberty interests that would be appropriate only in a substantive due process analysis,[16] reveals a "creat[ion of] substantive constitutional rights in the name of guaranteeing equal protection of the laws," *San Antonio Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1972).

CONCLUSION

The issue of physician-assisted suicide goes to the heart of our society's values. It is complex and stirs deep passions on both sides. States may choose to sanction the practice, and a few already have. But unless the Constitution says otherwise—and it does not—it is for the States to choose. "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary"—yet the lower courts here have read *Casey* to do precisely that. *Compassion* Pet. App. 162a (Kleinfeld, J., dissenting).

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[16] *Quill* Pet. App. 31a ("What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence . . . ?" (citation omitted).)

This Court should return the federal judiciary to its proper role in our nation's government. The judgments of the courts below should be reversed.

Respectfully submitted,

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APPENDIX

A-1

AAHSA Statement on End of Life Decision Making

AAHSA holds that all persons are sacred regardless of their physical or mental condition. Society should ensure decency at every stage of life, but especially at the end of life. Public policy should make it possible for individuals and families to have support during the closing moments of life.

- We affirm that individuals, especially the vulnerable populations served by our members, should neither be enslaved to technology nor assumed to be obligated to use every means to preserve life. We are opposed to a physician or other person assisting another in the taking of their own life.
- We affirm that a person should be able to use medications to relieve pain and discomfort, even if an unintended consequence of such therapy would be that life may be shortened.
- We affirm that intention is important just as we affirm that there is a valid distinction between removing life support and the deliberate use of an instrument or drug to end life. In the former instance, the natural processes attending death are allowed to proceed; in the latter a person causes death by deliberate act.

AAHSA recognizes the diversity of the association membership and the universal desire of its members to provide the most compassionate and positive setting possible for the end of life. As deliberation on these ethical, religious and medical issues proceeds either in legislative

or judicial forums, the association strongly affirms that the members should be in the forefront of pastoral and palliative care.

- We believe that each AAHSA member is responsible for deciding whether and how to participate in societal decision that will determine how the dying process is treated in public policy, and
- We recommend that, at a minimum, each member develop and make explicit its values and perspectives on all end of life decisions so that the consumer, the resident, and the family can make an informed choice about the use of its services.

Approved by the AAHSA Board of Directors, Oct. 26, 1996

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

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Petitioners,

—v.—

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents,

and

STATE OF WASHINGTON, *et al.*,
Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS
FOR THE SECOND AND NINTH CIRCUITS

BRIEF FOR THE INSTITUTE FOR PUBLIC AFFAIRS OF THE UNION OF ORTHODOX JEWISH CONGREGATIONS OF AMERICA ("UOJCA") AND THE RABBINICAL COUNCIL OF AMERICA, AS *AMICI CURIAE*, IN SUPPORT OF PETITIONERS

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INTRODUCTION AND INTEREST OF *AMICI*

This case raises the question whether individuals throughout the United States will be granted a right protected by the United States Constitution to seek and receive assistance in committing suicide. The courts below, on differing grounds, held that the states of New York and Washington could not proscribe assisting another person to commit suicide. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996); *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996).

Amici believe that these appellate courts have misread precedents handed down by this Court in recent years and have invented a "right to die" not contemplated by any provision of our Constitution.

The Union of Orthodox Jewish Congregations of America (the "UOJCA") is a non-profit synagogue umbrella organization for over 1,000 Jewish congregations throughout the United States. It is the largest Orthodox Jewish umbrella organization in North America. Through its Institute for Public Affairs, the UOJCA researches and advocates the legal and public policy positions promoted by the Orthodox Jewish community. The UOJCA has joined in filing briefs with this Court in many of the important cases which affect the Jewish community and American society at large. *See, e.g., Bd. of Ed. of Kiryas Joel v. Grumet*, 114 S.Ct. 2481 (1994); *Zobrest v. Catalina Foothills Sch. Dist.*, 113 S.Ct. 2462 (1993).

The Rabbinical Council of America is the sister organization of the UOJCA serving as the largest rabbinical organization in the world with a membership in excess of 1,000 rabbis.

We are supporting the petitioners in this case because we believe that the invention of a

constitutionally protected "right to die" is at odds with the language, history, policies, and sound judicial understanding of the Fourteenth Amendment of our Constitution.

We have obtained the consent of the parties in each action to file this brief. We acknowledge that the opinions of the lower courts and the briefs of the parties to this case have raised many of the arguments which this Court must consider in rendering its decision herein. *Amici* offer this brief to the Court with the purpose of clarifying the position of the Orthodox Jewish community and, importantly, the position of traditional Jewish teaching with regard to this issue. We believe this is particularly important in this case because the lower courts (the Ninth Circuit in particular) have purported to discuss the approach of ancient and historical traditions to assisted suicide.

SUMMARY OF ARGUMENT

1. The Court should reverse the holding of the Court of Appeals for the Ninth Circuit. This Court has clearly established that those rights deemed to be "fundamental" and thus protected by the Due Process Clause of the Fourteenth Amendment are those which are either implicit in our concept of ordered liberty or deeply rooted in this nation's traditions and history. A right to physician assisted suicide is neither. As demonstrated by the Court of Appeals for the Second Circuit in its discussion of this issue, such a right is clearly not implicit in our concept of ordered liberty. As *amici* demonstrate in this brief, to the degree that our nation's traditions and history are derived from our Judeo-Christian heritage, it is clear that this right cannot be said to enjoy such a pedigree either. The Jewish tradition clearly prohibits the active assistance of suicide. Moreover, in inventing a new "right to die," the Ninth Circuit ignored this Court's clear admonitions against expanding the list of fundamental rights extrapolated from the Due Process Clause. The Ninth Circuit also misread this Court's holdings in *Planned Parenthood v. Casey* and *Cruzan v. Director, Missouri Dept. of Health* to elicit this new fundamental right. Neither of those cases, properly read, provide a basis for the Ninth Circuit's recognition of a constitutionally protected "right to die."

2. The Court should reverse the holding of the Court of Appeals for the Second Circuit. First, the State of New York has not (nor has the State of Washington) established a classification scheme which treats similarly situated terminally ill persons differently. In fact, New York has not created a classification scheme with regard to terminally ill persons altogether, for its ban on assisting suicide applies to the healthy and the ill equally. Second, even assuming that New York has created such a classification scheme, it is rationally related to a host of state interests – most notably, the state's interest in ensuring that the value of every human life is respected -- and thus is constitutional under the Equal Protection Clause of the Fourteenth Amendment.

ARGUMENT

I. THE SUBSTANTIVE COMPONENT OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT DOES NOT CONTEMPLATE A FUNDAMENTAL LIBERTY TO PHYSICIAN ASSISTED SUICIDE.

A. THE "RIGHT TO DIE" IS NEITHER IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY, NOR DEEPLY ROOTED IN THIS NATIONS TRADITIONS AND HISTORY

The list of fundamental rights or liberty interests protected by the Fourteenth Amendment's Due Process Clause is short and well defined. Fundamental rights have oeen recognized in connection with child rearing, *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), family relationships, *Prince v. Mass.*, 321 U.S. 158 (1944), procreation, *Skinner v. Oklahoma*, 316 U.S. 535 (1942), and the decision as to whether or not to beget or bear a child, *Loving v. Virginia*, 388 U.S. 1 (1967); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Roe v. Wade*, 410 U.S. 113 (1973).

Moreover, this Court has warned that it will offer "great resistance" to attempts to expand that list. *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986). The Court in *Bowers* stated that "announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values." *Id.*, at 191. Instead, this Court must proceed on the basis of criteria set forth in its earlier seminal decisions. It must find that the suggested right is "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if it were sacrificed," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), or that the suggested right is a liberty "deeply rooted in this nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)(opinion of Powell, J.).

Accord., Bowers, 478 U.S. at 191-192.

In the context of these cases, even the Court of Appeals for the Second Circuit, which struck down New York's ban on physician assisted suicide on equal protection grounds, rejected the suggestion that such a fundamental right or liberty interest was to be newly created under the Due Process Clause. The *Quill* court held that this contended right "cannot be considered so implicit in our understanding of ordered liberty" and succinctly concluded that the "right to assisted suicide finds no cognizable basis in the Constitution's language or design," 80 F.3d at 724.

The Second Circuit also recognized that this suggested right is not deeply rooted in this nation's traditions and history. The court noted the prohibition of assisted suicide under the Common Law of England. *Amici* here offer for the Court's consideration the position of the Jewish legal tradition in its role as one of the central roots of this nation's legal structure.

It is well recognized that many of the laws of this nation are rooted in moral traditions brought to this country by her first settlers. Those moral traditions are derived from a familiar set of moral strands woven together in what has come to be referred to as our common Judeo-Christian heritage. It is well recognized that "if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed." *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986). *Amici* are in no way suggesting that these cases ought to be decided by this Court on the basis of religious teaching. We are contending, however, that the Judeo-Christian rejection of physician assisted suicide informs us that it is not a fundamental right to be accorded constitutional protection.

The approach to treatment of the terminally ill in traditional Jewish sources is one which venerates the infinite value of human life. Judaism not only recognizes the inestimable value

of each life, but of every moment of that life as well. Thus, one may violate the sabbath to free an individual from a collapsed building even if it is clear that the person will only survive a short time. Code of Jewish Law (I:329:4), *cited in* J.D. Bleich, *Treatment of the Terminally Ill*, Tradition, A Journal of Orthodox Jewish Thought (30:3) at 52 (hereinafter, Bleich).

Under traditional Jewish law, the preservation of life outweighs virtually every other religious commandment.[1] Thus, for example, one should violate the sabbath or eat non-kosher foods in order to save a life. Although Jewish tradition does not champion asceticism or suffering, it does recognize that "life with suffering is, in many cases, preferable to cessation of life and with it the elimination of suffering." Bleich, at 52. Thus, the rabbinic commentary to Genesis (9:5)[2] notes that the Bible seemingly repetitiously prohibits fratricide after having already condemned homicide because of a recognition that in certain circumstances the taking of a life might be wrongly perceived as motivated by love or compassion; it is precisely in those cases, the Bible instructs us, that such an act still constitutes murder. *See* Bleich, at 53. While Judaism recognizes personal autonomy and freedom as religious values, it has also long recognized that they are values which are not paramount to all others.

The traditional Jewish position goes so far as to say that one ought not take any action that might actively hasten

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[1] One must sacrifice his own life in the face of violating any of the three cardinal sins: murder, idolatry or adultery. Even in those circumstances, however, under Jewish law the individual is to permit himself to be killed by his adversary, not sacrifice his own life. Thus, the Ninth Circuit's reliance upon the events at Masada, 79 F.3d at 807 fn.24, is misplaced for there the Jews may not have followed the principles of Jewish law by killing themselves. *See*, F. Rosner, Modern Medicine and Jewish Ethics (1986), at 252 *et. seq.*

[2] "But your blood of your lives I will require; from the hand of every beast will I require it; and from the hand of man, from the hand of a person's brother, will I require the life of man."

the death of the terminally ill person. *See* Talmud, Tractate Shabbat, 151b.[3] Nevertheless, it does carve out an extremely narrow exception for an individual who is deemed to be in the "throes of death." A person in such a state is essentially defined as one who is irreversibly certain to die within seventy-two hours. Bleich, at 64, fn. 24. In such limited circumstances, Jewish law permits those treating the patient to withdraw treatment so that death may occur naturally.[4] While there is great debate in Jewish legal sources over the application of these principles it is clear that nothing may be done to actively speed the death process. *See* F. Rosner, *Jewish Perspectives on Issues of Death and Dying*, 11 Journal of Halacha and Contemporary Society, 50 (1986).

Despite these clear principles – the mandate of *Bowers* and the clarity that this "right" is neither implicit in our understanding of ordered liberty nor rooted in our nation's traditions -- the Court of Appeals for the Ninth Circuit felt compelled to invent a new fundamental liberty interest, the right to die, under the Due Process Clause by a patchwork reading of this Court's precedents. The holding of the Ninth Circuit must be rejected for several reasons.

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[3] One must not move the patient in a way that might hasten death, "the matter is like a flickering flame; as soon as one touches it, the light is extinguished."

[4] Thus, Jewish law recognizes the dichotomy between the active assistance of suicide and the passive withholding of treatment such that death results.

B. THIS COURT'S PRECEDENTS CLEARLY WARN AGAINST EXPANDING THE LIST OF ALREADY ESTABLISHED FUNDAMENTAL RIGHTS

This Court has warned lower courts not to discover new rights implicit in the Due Process Clause. In *Bowers* it clearly stated:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority. The claimed right pressed on us today falls far short of overcoming this resistance.

Bowers, at 194-195. The Second Circuit followed this mandate while the Ninth Circuit ignored it. In its forty-eight page opinion, the Ninth Circuit devotes little more than two footnotes to *Bowers* and baldly asserts that the precedent neither controls nor is inconsistent with its conclusion. *Compassion In Dying*, 79 F.3d at 813 fn.65. Such disregard for the clear admonition of this Court is

troubling and telling; it (along with an inexplicable reliance on polling data to determine current societal attitudes toward suicide, *Id.*, at 810) suggests that the Ninth Circuit panel was sitting as a superlegislature, rather than as a court organized under our constitutional structure.

Respondents and their *amici* are, at bottom, pressing this Court to ignore its precedents which counsel resistance to expanding the category of fundamental rights. On this basis alone, the Court should rule in favor of petitioners.

In looking to justify the creation of this new liberty interest, the Ninth Circuit relied upon this Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) which, after reviewing its previous decisions to grant constitutional protection for the fundamental rights of marriage, procreation, contraception, family relationships, child rearing, and education, stated, at 851:

> These matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, or meaning, of the universe, and of the mystery of human life.

The Ninth Circuit agreed with the district court that these sentences were "highly instructive" and "almost prescriptive" for creating a liberty interest in a person's choice to commit suicide. 79 F.3d at 813 (citations omitted).

It must be recognized that a majority of the justices in *Casey* indicated their belief that the underlying case of *Roe v. Wade* was either incorrectly decided or had sufficient doubts regarding its correctness to refrain from reaffirming it on its original (fundamental liberty) grounds. Rather, *Casey*'s majority was formed out of a need to respect the principles of *stare decisis*,

not the ringing reaffirmation of the fundamental right of more than twenty-years earlier. *See Casey*, 505 U.S. at 854. This makes *Casey* a most tenuous foundation for minting a new fundamental constitutional right. *See* Chopko, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 576 (1995).

As stated above, this Court has consistently resisted finding constitutionally protected liberty interests and has only done so after a careful and thorough analysis of the right in question. That being the case, it is inconceivable that a few passages found in *Casey* were intended by this Court as a springboard for courts to employ in the creation of new fundamental rights. That the Ninth Circuit believes so demonstrates how far it has strayed from this Court's precedents.[5]

The Ninth Circuit also based its holding upon *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), in which this Court held that "a competent person has a protected liberty interest in refusing unwanted medical treatments" even where such a refusal will inevitably result in death. *Id.*, at 278. From that narrow statement, the Ninth Circuit conjured a broad right to "hastening one's own death." 79 F.3d at 816. Once again, the Ninth Circuit's reasoning is flawed. The liberty interest discussed in *Cruzan* was necessarily limited to the refusal of unwanted medical treatment. This is apparent form the Court's derivation of this liberty interest from the well established tort law doctrine of informed consent. By virtue of an individual's right to determine who may treat his own body, the Court derived a

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[5] Ironically, the Ninth Circuit's first opinion in this litigation, *Compassion In Dying v. Washington*, 49 F.3d 586, 590 (9th Cir. 1995), accurately characterized such an attempt to base the creation of a new fundamental right to die on these abstract passages. The court stated: "To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these sentences 'almost prescriptive' in ruling on a statute proscribing the promotion of suicide is to ... ignore the differences between regulation of reproduction and the prevention of the promotion of killing a patient at his or her request.

corollary right to refuse the treatment of that same body. *Id.*, at 269-270. It is a much greater leap, however, to then conclude that one may seek assistance in afflicting his own body.

Moreover, the *Cruzan* Court emphasized the narrowness of its holding:

> This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897), where we said that in deciding "a question of such magnitude and importance…it is the [better] part of wisdom not to attempt by any general statement to cover every possible phase of the subject.

497 U.S. at 277. Consequently, *Cruzan* ought to be read as limited solely to its factual context – the right to refuse unwanted medical treatment – and not to create a broader right to hasten one's own death.

II. THE PROHIBITION OF PHYSICIAN ASSISTED SUICIDE IS RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS AND, THEREFORE, DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

Having demonstrated that there is no fundamental right to physician assisted suicide contained in the Fourteenth Amendment, we proceed to the review of this state legislation under the Equal Protection Clause of the Fourteenth Amendment. It was upon this basis that the Court of Appeals for the Second Circuit struck down New York's proscription of assisted suicide. The Second Circuit held that New York lacked a rational basis for treating differently, what it deemed to be, similarly situated classes of terminally ill persons.

A. THE STATES HAVE NOT LEGISLATED THE DISPARATE TREATMENT OF SIMILARLY SITUATED INDIVIDUALS

Prior to proceeding to a discussion of rational-basis review, however, a threshold issue must be raised. Central to any equal protection analysis, including that engaged in by the Second Circuit, is the treatment by the state of similarly situated individuals (or classes of individuals) differently. To embark upon its equal protection analysis, the Second Circuit interpolated the creation of two categories of terminally ill persons into the New York statutory scheme. Thus, after reviewing the principles of rational-basis review, the court asserted that:

> New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering

prescribed drugs.

80 F.3d at 729. What is overlooked by this reasoning, however, is that the statute prohibiting the assisting of suicide does not speak to the terminally ill alone. It is a provision of the Penal Law that is generally applicable to those who would assist in the suicide of a perfectly healthy individual just as much as one who is terminally ill.[6] *See*, N.Y. Penal Law 125.15, 120.30. Thus, it is inappropriate to read as one whole cloth of this generally applicable provision and the legislature's decision to permit the refusal of continued life-support, N.Y. Pub. Health Law 2980-94, or resuscitation, N.Y. Pub. Health Law 2960-79.[7]

It has long been recognized that legislatures may seek to address various issues which confront our society piecemeal and need not address all phases of an issue at once and still have its enactments survive equal protection review. *See Williamson v. Lee Optical*, 348 U.S. 483 (1955). Here, the State of New York determined years ago that giving assistance to suicide was to be prohibited. *See Quill*, 80 F.3d at 733 (opinion of Calabresi, J., concurring). The fact that in more recent years the legislature has determined to permit a narrow class of individuals – the terminally ill on life-support – to arrange for the discontinuation of the active sustaining of their lives or for ordering that medical professionals do not intervene and resuscitate them should the life support mechanisms fail, does not indicate that the legislature has created a classification scheme among the terminally ill or as between the terminally ill and all

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[6] Indeed, one of the most troubling aspects of this case is that those who advocate for a constitutionally protected "right to die" do not convincingly address how this right will be restricted to those who are terminally ill and wish to "die with dignity" as opposed to others who may for whatever reason decide that they no longer wish to live. We address this point further below.

[7] It is similarly the case that Washington's statute struck down by the Ninth Circuit is a statute of general applicability contained in its penal code section. *See*, Wash.Rev.Code 9A.36.060.

other citizens.

Thus, the Second Circuit erred in holding that the New York statute violated the Equal Protection Clause for irrationally classifying groups of terminally ill persons differently. In fact, New York's laws do not classify the terminally ill into different categories. Therefore, rational-basis review is inapplicable.

B. THE STATUTES AT ISSUE ARE RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS

Even assuming that these statutes are to be read together to create a statutory classification scheme that treats similarly situated persons differently, such schemes still fulfill the requirements of the Equal Protection Clause as enunciated by this Court and are constitutional.

As noted by the *Quill* co[illegible]t below, "[t]he general rule... is that state legislation carries a presumption of validity if the statutory classification is 'rationally related to a legitimate state interest.' *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985)." 80 F.3d at 725. Left unmentioned by the *Quill* panel was this Court's restatement of the principles underlying rational-basis review as succinctly summarized in *Heller v. Doe By Doe*, 113 S.Ct. 2637, 2642 (1993). There, this Court reaffirmed the fact that:

> rational-basis review in equal protection analysis is not a license for courts to judge the wisdom, fairness, or logic of legislative choices...[n]or does it authorize the judiciary to sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines. For these reasons, a classification neither involving fundamental rights nor proceeding along suspect

> lines is accorded a strong presumption of validity. Such a classification cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose. Further, a legislature that creates these categories need not actually articulate at any time the purpose or rationale supporting its classification. Instead, *a classification must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification...moreover...the burden is on the one attacking the legislative arrangement to negate* [sic] *every conceivable basis which might support it.*

Id. at 2642-2643 (internal quotes and citations omitted, emphasis supplied).

A host of rational legislative policy determinations underlie the decisions by these states to prohibit physician assisted suicide. In fact, many of these state interests and policy decisions are outlined, albeit rejected, by the majority opinion for the Ninth Circuit, 70 F.3d 816-831, and by the dissent filed in that case. *Id.* at 851-855. Those state interests include: (1) a state's interest in preserving life as recognized by this Court in *Cruzan*, 497 U.S. at 282; (2) a state's interest in preventing suicide; (3) a state's interest in assuring that third parties do not persuade persons contemplating suicide to do so; (4) a state's interest in safeguarding the well-being and interests of those close to the person who commits suicide; (5) a state's interest in protecting the integrity of and reliability upon the medical profession as one persons may seek reliable assistance.

Amici would note for the Court on this occasion one central and compelling state interest and policy that should alone compel the rejection of respondents' cause. Proponents of

protecting the practice of physician assisted suicide, especially as a fundamental right protected by the Constitution, consistently point to the importance of respecting the autonomous decision-making power of the individual. Taken to its logical conclusion, however, such a policy provides no reasonable rationale why this choice should be provided only to the terminally ill. It is illogical to suggest that any other class of citizens may be prohibited from exercising this choice if it is granted to the terminally ill.[8]

Some will suggest that society ought to grant this choice of suicide only to the terminally ill out of respect for their unique plight and that the host of state interests identified heretofore continue to apply to the able-bodied among us. This is the very sort of decision which our constitutional structure confers upon the legislative branch, not the courts. In this context, the legislatures have determined that such an option ought not to be granted to the terminally ill for they recognize that "[s]ingling out the terminally ill as a class of people who 'deserve' to have their suicidal impulses respected...is logically incoherent unless one presupposes that, in some objective sense, their live[s are] not worth living. But, as a civilized society, we make no such claim with respect to any human being." Chopko, *Assisted Suicide*, 70 Notre Dame L.Rev. at 576.

The ancient lineage, outlined above, of the approach to the terminally ill found in traditional Jewish sources has made its way into our society's laws by way of its common Judeo-Christian heritage. While "[a]ncient lineage of a legal concept does not give it immunity from attack for lacking a rational basis," this Court has recognized that the very fact "[t]hat the law has long treated the classes as distinct...suggests that there is a commonsense distinction between [the two categories at issue.

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[8] The Ninth Circuit approvingly relied on this point in its first review of Washington's statute. 49 F.3d at 590-591 ([under this reasoning there is nothing to prevent] "the depressed twenty-one year old, the romantically devastated twenty-eight year old, [or] the alcoholic forty-year old" from also claiming a fundamental right to die.).

Heller, 113 S.Ct. at 2646. Thus, these laws of the State of New York and the State of Washington must be found to survive rational-basis review.

CONCLUSION

In its opinion below, the *Quill* court wondered "what interest can the state possibly have in requiring the prolongation of a life that is all but ended?" 80 F.3d at 729. The detached, doctrinal answer is that under a rational basis review it is the legislatures and not our courts which are to make such a determination. The more appropriate answer, and the one which *amici* ask this Court to resoundingly affirm, is that our nation, and its living Constitution, venerates and cherishes the value of every human life as our ancient traditions have for centuries.

For the foregoing reasons, the judgments of the Courts of Appeals should be reversed with instructions to enter judgments for the defendants.

Respectfully submitted,

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Nos. 95-1858 and 96-110

In the Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL KLAGSBRUN, M.D., AND HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

BRIEF OF SENATOR ORRIN HATCH, CHAIRMAN OF THE SENATE JUDICIARY COMMITTEE; REPRESENTATIVE HENRY HYDE, CHAIRMAN OF THE HOUSE JUDICIARY COMMITTEE; AND REPRESENTATIVE CHARLES CANADY, CHAIRMAN OF THE SUBCOMMITTEE ON THE CONSTITUTION OF THE HOUSE JUDICIARY COMMITTEE, AS AMICI CURIAE IN SUPPORT OF THE PETITIONERS

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NOVEMBER 12, 1996

QUESTION PRESENTED

Whether state laws prohibiting assisted suicide are unconstitutional.

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INTEREST OF THE AMICI

These *amici curiae* have the honor of serving as chairmen of the Judiciary Committees of the United States Senate and House of Representatives, and of the Subcommittee on the Constitution of the House Judiciary Committee. In that capacity, the *amici* are directly concerned with the relationship of judicial and legislative authority under the Constitution. In addition, *amici* Hyde and Canady have conducted hearings on the subject of assisted suicide in the United States.

ARGUMENT

This *amicus curiae* brief is addressed to the most fundamental question of modern constitutional theory: When, and under what conditions, may courts invalidate duly enacted state or federal laws on the basis of unenumerated constitutional rights? Put differently: What are the respective roles of courts and legislatures in resolving contested questions of justice and political morality? On the one hand, we recognize that over the 209 years since adoption of the Constitution, the courts have, from time to time, exercised the power of judicial review in cases not compelled by the plain text of the Constitution, and rightly so. On the other hand, an unbridled power — whether called "substantive due process" or something else — to invalidate laws whenever five or more members of this Court deem them unwise or unjust would displace the legislative branch as the primary lawmaker. The purpose of this brief is to show that a principled middle ground exists, in which the courts may recognize and enforce constitutional rights in a fashion that gives due respect to the coordinate branches of government and the traditions of the people.

Under this approach, which is based on the text and history of the Fourteenth Amendment as well as leading precedents of this Court, the decisions of the courts below must be reversed. Assisted suicide is not, and never has been, recognized by this Nation as a protected constitutional right. In this brief, we focus on the due process argument of the Ninth Circuit, leaving the argument of the Second Circuit to others. But the institutional, prudential, and logical considerations we address apply to both decisions.

I. Assisted Suicide Involves Highly Contested Issues Of Morality And Public Policy, Which The Judiciary Is Ill-Suited to Resolve

A. Laws Against Assisted Suicide Are Supported By Serious And Substantial Ethical Justifications

We begin with a statement that may seem obvious, but must be the starting point for thinking about this constitutional controversy: the laws against assisted suicide have substantial moral and political justifications. These laws cannot be dismissed as arbitrary, antiquated, or unthinking.

Thoughtful and experienced doctors, ethicists, philosophers, lawyers, theologians, and advocates for patients have offered cogent reasons why assisted suicide should not receive the formal sanction of law. The professional associations in the disciplines closest to the problem — the American Medical Association, the American Psychological Association, the American Geriatric Society, and the American Bar Association among them — have all concluded that assisted suicide should not be made legal. The two most thorough and distinguished studies undertaken of the issue — one under the auspices of the State of New York and one under the auspices of the British House of Lords — both resulted in *unanimous* recommendations that laws against assisted suicide (as well as euthanasia) should be retained. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994) [hereinafter cited as "NEW YORK REPORT"]; *Report of the Select Committee on Medical Ethics*, House of Lords, Sess. 1993-94. On April 29, 1996, the Subcommittee on the Constitution of the Committee on the Judiciary of the House of Representatives conducted hearings in which ethicists, physicians, legal experts, and specialists in the care of terminally ill, suffering, and disabled patients presented their perspectives on the issue. *Assisted Suicide in the United States:* Hearings Before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess. (1996) [hereinafter cited as "HOUSE HEARINGS"]. We commend those reports and hearings to this Court's attention.[1]

[1] For the convenience of the Court, we have lodged copies of the HOUSE HEARINGS with the Clerk. We understand that copies of the New York and House of Lords reports have been lodged by others.

We will briefly summarize some of the reasons for prohibiting assisted suicide set forth in these sources, not because we believe the Court should resolve the underlying moral-political dispute, but because the lower courts' decisions were based on a mistaken belief that there are no plausible state interests (excluding religious dogma) in protecting the life of a terminally ill patient. In reaching their conclusions, the courts gave no deference to the nearly unanimous judgments of state legislatures and state courts, nor to the similar conclusions of distinguished ethicists, physicians, and others who have devoted their lives to the care of suffering patients. Judge Reinhardt's opinion for the Ninth Circuit dismissed contrary opinions as "cruel" (Pet. App. A75), "untenable" (*id.* at A76), "disingenuous and fallacious" (*id.* at A85), "meretricious" (*id.*), "ludicrous," (*id.*), and "nihilist" (*id.* at A98). The court praised its own view as "more enlightened" (*id.* at A76). The court characterized hundreds of years of common law precedent as "taboos," linked to superstition (*id.* at A46); brushed aside the central text of medical ethics, the Hippocratic Oath, saying that it "does not represent the best or final word on medical or legal controversies today" and that to follow it "literally" would be "preposterous" (*id.* at A95); and criticized arguments made by the American Medical Association and American Geriatric Society (among others) as reflecting "a misunderstanding of the proper function of a physician" (*id.* at A91). The sublime arrogance of these judicial pronouncements highlights the danger of allowing courts to set social policy, in defiance of legislatures and referenda, on the basis of their own (often ill-informed) philosophical intuitions.

Although there are many arguments in favor of laws prohibiting assisted suicide, we will summarize four of the most important.

First, even assuming *arguendo* that in a limited number of cases assisted suicide might be ethically permissible, many knowledgeable observers believe that the problems of abuse would be so widespread and uncontrollable that formal legal and ethical

prohibition remains necessary.[2] The harsh reality is that a more expeditious death for terminally ill patients would often serve the interests of others, especially in this era of managed care and exploding medical costs. A patient weakened by illness and pain is peculiarly susceptible to influence from family members or doctors who are in a position of trust. It will not be difficult for these individuals, for their own reasons, to exert subtle — but powerful — pressure on a frail patient to "choose" the convenient option of a speedy death. Even the suggestion by a well-meaning doctor that a patient should consider the option of death will inevitably convey the message that — in the doctor's informed professional opinion — her life is no longer worth living.[3]

For every suffering person who makes a rational, informed choice to die, there will be others — perhaps many times as many — on whom that "choice" is effectively imposed. And there will be no way to tell the difference.

Safeguards, no doubt, will be proposed. Indeed, the Ninth Circuit professed faith that "sufficient protections" can be enacted. Pet. App. A103-A104. Unfortunately, these were expressions of hope rather than descriptions of experience. Many physicians and ethicists doubt that effective safeguards can be devised or enforced — especially since typically no one involved in the death will have the incentive to expose wrongdoing, and the interactions involved are cloaked in the confidentiality of the doctor-client relationship. The American Medical Association's code of Medical Ethics, for example, rules out physician-assisted suicide partly on the ground

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[2] See NEW YORK REPORT, at xii, 102, 119-20, 140.

[3] See Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 113; Leon Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 409 (1996).

that it "would be difficult or impossible to control."[4] Even counsel for the respondents, Professor Tribe, has observed:

> [T]he judiciary's silence regarding [the right to determine when and how to die] probably reflects a concern that, once recognized, rights to die might be uncontainable and might prove susceptible to grave abuse * * * . [T]he resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting persons, may endanger personhood.

Laurence H. Tribe, *American Constitutional Law*, § 15-11, at 1370-71 (2d ed. 1988).

The specter of widespread abuse and exploitation is not based on mere speculation. Studies of assisted suicide and euthanasia in the Netherlands, where safeguards are stringent on paper, show that those safeguards are routinely disregarded. Although medical guidelines recognize the right to die only based on the patient's own informed and voluntary decision, a survey of 300 physicians disclosed that over 40 percent had performed euthanasia *without* explicit consent. In 1990, in addition to 2,300 cases of active euthanasia with consent and 400 cases of assisted suicide, there were over 1,000 cases of active nonvoluntary euthanasia performed without the patient's knowledge or consent, including roughly 140 (14 per cent) where the patient was fully competent. Comparable rates of nonvoluntary euthanasia in the United States would be roughly 20,000 per year.[5] And these numbers do not even include

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[4] Opinion of the Council on Ethical and Judicial Affairs, American Medical Association, Opinion 2.211. For the most extensive discussion of these issues, see Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1 (1996). See also NEW YORK REPORT, at 73; Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 316-17 ("it is difficult to imagine adequate safeguards which could effectively guarantee that patients' decisions to request assisted suicide were unambivalent, informed and free of coercion"); Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 115.

[5] See John Keown, *Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the Var Der Maas Survey*, in Lucke Gormally,

cases where "consent" was extracted by means of undue influence, psychological coercion, or skewed information.

Giving choices to the vulnerable is not always liberating. A young woman is not more "free" if the law allows her to contract with a pimp; a young man is not more "free" if a pusher can sell him crack cocaine; a child is not more "free" if he or she can "consent" to sexual advances by adults; people are not more "free" if they can voluntarily sell themselves into slavery. Nor is an ill person necessarily more "free" if he can agree to kill himself. Indeed, the mere availability of assisted suicide as a socially-legitimated alternative may impel some who would prefer to live to accept this course out of feelings of guilt or shame about the burdens (financial and otherwise) that the choice of continued living would impose on their families. These laws are not an instance of some people "imposing their morality" on others. They result from citizens reflecting on the conditions that they may face at the end of life, and establishing rules that will protect all of us, when we are weakest and most vulnerable.

Second, if patients' requests for assistance in suicide are honored, many will die unnecessarily. According to medical experts, the desire to commit suicide (even among the terminally ill) is typically associated with clinical depression, which is a treatable disease.[6] The New York State Task Force reported: "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at time of death. Depression, accompanied by symptoms of hopelessness and helplessness, is the most prevalent condition among individuals who commit suicide." NEW YORK REPORT at 11; see also *id.* at 13 ("In one study of terminally ill patients, of those who expressed a wish to die, all met diagnostic criteria for major depression"); J.H. Brown, *et al.*, *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. of Psychiatry 208 (1986).

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ed., EUTHANASIA: CLINICAL PRACTICE AND THE LAW 193, 209, 221-25 (1994); Callahan & White, *supra*, 30 U. Rich. L. Rev. at 15-18. See also Carlos F. Gomez, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 106-13, 114-15.

[6] See Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 103-06.

When treated for depression, patients typically cease to desire suicide. NEW YORK REPORT at 26 (treatment of depression "resulted in the cessation of suicidal ideation for 90 percent of these patients").

Much of the desire to commit suicide is also traceable to insufficiently aggressive measures to alleviate pain.[7] When a suicidal patient is helped to deal with pain and depression, he or she typically is restored to the natural desire to live. To give patients the "right" to obtain assistance in suicide is to license the killing of persons who often are simply in need of help, which modern medicine can give. Professor Herbert Hendin, a professor of psychiatry at New York Medical College, testified:

> Patients who request euthanasia are usually asking in the strongest way they know for mental and physical relief from suffering. When that request is made to a caring, sensitive, and knowledgeable physician who can address their fear, relieve their suffering, and assure them that he or she will remain with them to the end, most patients no longer want to die and are grateful for the time remaining to them.

HOUSE HEARINGS at 115-16.

Since American doctors are notoriously uninformed about proper pain prevention techniques,[8] as well as depression,[9] it is almost certain that many people will be induced to die when instead they could receive effective palliative treatment.[10] The ethical

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[7] NEW YORK REPORT, at 16-17; Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 309-10.

[8] NEW YORK REPORT, at 33 ("pain is often overlooked by health care providers"); *id.* at 43 ("the delivery of pain relief is grossly inadequate in clinical practice"); Testimony of Dr. Kathleen Foley, Chief of Pain Service at Memorial Sloan-Kettering Cancer Center, HOUSE HEARINGS at 18-20.

[9] NEW YORK REPORT, at 32; *id.* at 32-33 (study found that fewer than 15 percent of depressed residents of a nursing home for the elderly had been correctly diagnosed, and fewer than 25 percent had been treated for depression).

[10] See NEW YORK REPORT, at 40 ("modern pain relief techniques can alleviate

problem is magnified by the fact that economically disadvantaged patients and members of racial and ethnic minorities are the most likely to lack proper treatment for pain and depression,[11] and thus the most likely to "choose" — unnecessarily — to die. Other groups especially at risk are women and the elderly.[12]

Third, if death is defined as a "mercy," it will be difficult to justify refusing this mercy to broader and broader categories of sufferers. It is therefore misleading to confine one's attention (as the lower courts did) to "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (Pet. App. A116).[13] For example, the moral arguments supporting assisted suicide for terminally ill patients who are able to self-administer the killing agent apply just as strongly to similar patients who cannot do the deed for themselves. Thus, assisted suicide will merge into voluntary active euthanasia.[14] And the moral arguments supporting assisted suicide for the terminally ill apply with as much force — maybe more — to persons who face not a few weeks or months, but years of pain that seems to them intolerable. Thus, assisted suicide for the terminally ill will almost surely merge into assisted suicide for those with incurable chronic

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pain in all but extremely rare cases"); Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 310, 314-15.

[11] NEW YORK REPORT, at 44, 46; Testimony of Dr. Carlos Gomez, House Hearings at 412.

[12] NEW YORK REPORT at 44; see also *id.* at 33.

[13] It is a striking example of the illogic of the decisions below that they declare the longstanding distinction between assisted suicide and refusal of life-sustaining treatment to be a distinction without a difference, only to propose new distinctions that have far less logical, empirical, or ethical justification. See Yale Kamisar, *The Right to Die: On Drawing (And Erasing) Lines*, 35 Duq. L. Rev. 481 (1996).

[14] *Id.* at 513-19; Dan W. Brock, *Voluntary Active Euthanasia*, Hastings Center Rep., Mar.-Apr. 1992. Indeed, the Ninth Circuit intimated that it did not regard the distinction between assisted suicide and active voluntary euthanasia as significant. Pet. App. A100-101.

conditions.[15] Persons with serious disabilities will be particularly at risk.[16] And (as cases like *Cruzan* so eloquently demonstrate), the argument for assisted suicide for competent adults will apply with seemingly equal force to those unable to consent for themselves, whose "right to die" will be exercised by surrogates. If death is seen as a mercy, why confine it to those fortunate enough to be able to consent? The same corrosive skepticism that the courts below evinced toward the distinction between refusal of treatment and active assisted suicide will be equally potent to dissolve all of the other limitations on this newfound right.

It is even difficult to understand why, under the reasoning of the Ninth Circuit, the mercy of assisted suicide should be denied to persons who, for reasons other than ill health, conclude that the suffering of life is unbearable. Physical pain and impending death are not the only — and not necessarily the most serious — reasons to desire a release from these mortal coils. Many of the examples in the lower court's opinion of suicide in other cultures involve suicide for reasons of honor, guilt, or grief. Pet. App. A40-A42. Patients are free to refuse life-sustaining treatment for any reason whatsoever. Once we conclude that death is a matter of personal autonomy — of privacy — where can we stop?[17]

Fourth, and most fundamentally, by making death a legally available "choice," we will inevitably change the way our culture perceives the final stages of life. When death is not an official option, the focus of the patient, the patient's family, the doctor, and the system is on what can be done to make the patient's life easier and better. If death becomes an approved social option, both the patient and the system will tend, instead, to focus on whether continued care is "worth it." The patient, aware of the burden she is imposing on loved ones, may well conclude that she "owes it"

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[15] See Kamisar, *supra*, 35 Duq. L. Rev. at 502-13.

[16] Testimony of Diane Coleman, in HOUSE HEARINGS, at 53-54; Statement of Diane Coleman and Carol Gill, *id.* at 53-70.

[17] The implications of this decision extend beyond assisted suicide and euthanasia. For example, what will be the effect on laws allowing the use of physical force to prevent suicide?

to her family to commit suicide. The decision to cling to life may come to be regarded as wasteful, irrational, and selfish. In the uniquely vulnerable circumstances of the lingering patient, the "right to die" will become, for many, the duty to die. See NEW YORK REPORT at 95. One blessing of the current law is that it relieves the elderly and the infirm of the need to justify their continued existence.

Even if the laws against assisted suicide are rarely enforced, they still have the effect of expressing society's deep commitment to the protection of human life. In combination with the ethical precepts of the medical profession, these laws ensure that assisted suicide remains a highly exceptional activity, rarely suggested or initiated by physicians. If assisted suicide is recognized as a "right," it will become both routinized and common. It is not obvious that patients would be better off.

These are among the reasons that have persuaded the New York legislature and the people of the State of Washington (along with most other states) to retain their laws against assisted suicide. These *amici* find the arguments compelling. We fear the consequence of the liberation of death, especially for the most vulnerable among us. But we do not ask this Court to adopt our view of the moral consequences of legalized assisted suicide. Indeed, the point we wish to make is that this case should not be decided on the basis of the Justices' own assessment of the weight of the competing moral arguments. Rather, as members of the legislative branch of government, we maintain that this is not a question for courts to decide — or more precisely, that there is no legitimate basis in the Constitution of the United States for overturning the laws that have been enacted by the various states on this issue.

B. Constitutional Judicial Review Is Too Inflexible An Instrument For The Decision Of Such Questions

Even apart from the specifics of constitutional doctrine, there is every reason for courts to be wary about overturning duly enacted legislation on the basis of untried and uncertain moral and philosophical arguments, where the result is bereft of support in directly relevant constitutional text or in national experience. It may well be true that attitudes about the end of life have changed,

or will change, in response to technological developments and their attendant economic and emotional consequences. But it would be a grave mistake for the federal courts to leap in and attempt, prematurely, to resolve the issue or to accelerate the pace of change. Even on the heuristic assumption that laws against assisted suicide and euthanasia should be relaxed (which these *amici* doubt), it is better that reform take place in decentralized and accountable institutions.

The great institutional strength of courts is their ability to provide uniform enforcement of legal principles, with consistency across parties, regions, and time periods, treating like cases alike. Where operative principles are in flux and the consequences of new approaches are unpredictable, however, that virtue becomes a vice. Constitutional judicial review is too inflexible a process to deal sensitively and appropriately with a matter such as this.

First, by locating the right to die in the federal constitution, the courts below nationalized the issue and eliminated the possibility of state variation and experimentation. Justice Brandeis's characterization of the states as "laboratories of democracy" is no cliche; it is an apt description of one of the principal virtues of a federal system. In this case, there is no serious argument that national uniformity is necessary or even desirable. The State of Oregon has undertaken an experiment in physician-assisted suicide that — however misguided it may appear to many of us — will cast light on the practical consequences: on the efficacy of the safeguards against abuse, on the ability of the medical profession to recognize and treat clinical depression and pain in patients requesting suicide, on the robustness of the lines drawn between permitted and forbidden forms of the right to die, and on the danger that death will come to be perceived as a duty owed to family and society. To treat this social policy question as controlled by federal constitutional law is to eliminate the possibility of a multiplicity of approaches, and of regional variation in light of differences in social and moral perceptions.

Even a leading advocate of physician assisted suicide, and sometime co-author with respondent Quill, has recognized that the right to die should be the subject of legislative reform rather than judicial fiat:

> Legalization of physician assisted suicide should be understood not as a matter of recognizing rights but as a policy aimed at making available a compassionate option of last resort for competent, terminally ill patients. Since we do not know whether such a policy will produce more good than harm, it should be viewed as an experiment.
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> Our federal system of government has often been touted as offering "a laboratory of the states," with which to experiment concerning social policy. In the case of a morally controversial issue, subject to competing arguments pro and con, it is better that policy experimentation occur piecemeal, by the various decisions of the legislatures or voters of the states, rather than wholesale, by means of the constitutional adjudication of the federal courts.

Franklin G. Miller, *Legalizing Physician-Assisted Suicide by Judicial Decision: A Critical Appraisal*, 2 BioLaw S:136, S:144 (Special Section, July-Aug. 1996).

Second, by their nature constitutional judicial decisions must be "grounded truly in principle"; they may not be "compromises with social and political pressures." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 865 (1992). The lines drawn by courts, under the authority of the Constitution, must be defensible at the level of constitutional principle.

Yet not every aspect of social life can be governed by crisp and principled rules. Sometimes, the best and most peaceful solution to contentious moral conflicts in society is not to award the brass ring to one side or the other, but to construct compromises that allow each contending force to believe that the system has been responsive to their deeply held convictions. Legislatures are good at that. Whatever one may think of legislators as moral deliberators, few would dispute that they have the expertise and incentive to resolve social conflict in a way that minimizes political opposition and resistance. The legislative answer may not appear pure from a philosophical or analytical perspective, but it is likely to reduce social discord. And even if legislatures prove unable to forge a stable consensus, contending social forces are more likely to accept the outcome of a process in which their voices were heard

than an imposed solution in which their elected representatives were not entitled to a significant role.

The right to die may well be such an issue. Certainly, the public is seriously divided. Passions run high. The various lines that might be drawn — refusal of treatment versus suicide, assisted suicide versus active euthanasia, terminal illness versus chronic pain or disability, actual consent versus imputed consent, intolerable pain versus other conditions that harm the quality of life, one set of safeguards versus another, and so forth — are, each of them, arbitrary in their own way. Each of them attempts to allow the dying patient some greater degree of control over the circumstances of his death, while at the same time upholding the society's obligation to honor life and protect the vulnerable. Each tries to reconcile two honorable impulses that are, in principle, irreconcilable: autonomy and protection. Prudential compromises are difficult to justify as interpretations of the Constitution, but are the everyday product of legislative action.

Third, and most importantly, courts are seriously constrained in their ability to change their policy in response to experience and criticism. Each decision of the Court is said to be based on an interpretation of the Constitution, and it strains public credulity that the meaning of such an old document would change very rapidly, very often. The doctrine of *stare decisis* thus creates a presumption in favor of existing doctrine. Stability is a source of judicial strength and legitimacy. But with this strength comes a caution: just as the Court is properly reluctant to jettison a constitutional doctrine that it has embraced, the Court should be reluctant to embrace novel constitutional doctrines that may require modification in the future.

This case is a perfect example. If the Court joins the lower courts in creating a right to assisted suicide, neither Congress nor the states will be able to explore contrary policies. If that judgment proves to be misguided, great injury will have been done to thousands of vulnerable persons, in every state in the Union, until the Court brings itself to acknowledge the mistake and reverse the decision. On the other hand, if the Court reverses the judgments below, debate on the issue will proceed. The several states will be free to pass laws allowing assisted suicide or euthanasia in such circumstances and under such safeguards as they may deem

advisable. If experiments with liberalized laws on this subject are successful, it is likely that still more states will follow suit. If they prove misguided (as we expect), these states can reverse course, and the other states will profit by their example.

One final observation about the institutional capacities of courts and legislatures bears mention. Since the *Carolene Products* decision, prominent strains of constitutional theory have maintained that the judiciary should be most willing to intervene in cases where the adverse consequences of the challenged law are borne by discrete and insular minorities whose interests may not have received their just weight in legislative deliberations. See generally John Hart Ely, DEMOCRACY AND DISTRUST (1980). Whatever the merits of that view, we wish to stress that it has no application to this case. When the New York legislature decided to retain its laws against assisted suicide, or the people of Washington made a similar decision by referendum, they were not legislating for a discrete and insular minority. They were legislating for themselves and for their loved ones, behind a veil of ignorance that denies all of us the knowledge of what our condition may be in the final days of our lives. There is no reason to distrust the conclusions that they reached.

If anything, the biases of the political process run the other way: in favor of fewer protections against euthanasia than may be in the best interests of those immediately affected by the law. Studies indicate that the frail elderly, who are most likely to feel the effects of the law in this area, are significantly less likely to favor legalizing assisted suicide than the young and healthy. Harold G. Koenig, et al., *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives of Internal Med. 2240 (Oct. 28, 1996) (only 34% of elderly outpatients favor legalizing physician-assisted suicide, as compared to 55.6% of their families; female, black, and economically disadvantaged patients were most likely to oppose it). This is not surprising. From the vantage point of youth and health, the quality of life enjoyed by disabled, chronically ill, or dying people appears excruciatingly low. But persons experiencing those conditions, whose point of comparison is not youth and health but death, often cling to life with increased tenacity. Self-interest, both individual on the part of family members and collective on the part of health

care providers, also plays its part in shaping opinion on this issue. The logic of *Carolene Products*, in this context, is that courts should be more active in ensuring that the protections against unwanted death are adequate than in ensuring that the political process is sufficiently receptive to the right to die.

II. The Decision Of The Ninth Circuit Is Antithetical To This Court's Traditional Approach To Interpreting The Fourteenth Amendment

A. The Fourteenth Amendment Takes Its Bearings From The Experience Of The Nation, Not From The Moral Intuitions Of Federal Judges

Constitutional judicial review had its birth in the recognition that a written constitution reflects the limits that the people of the United States have placed upon their government. *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 176 (1803). It was no part of the theory of judicial review that the courts are superior to the people in their judgments of what those limits should be. It is revealing that the examples deployed by Chief Justice Marshall in his great exposition of the theory of judicial review consisted of explicit limitations unambiguously violated by the government. *Id.* at 178. In such cases, it was clear that judicial review served to enforce the will of the people rather than the will of the judiciary.

Nonetheless, in the 209 years since the Constitution was adopted, this Court has not infrequently held unconstitutional acts of the political branches that do not violate any express provision. The most common basis for so doing is the Due Process Clause of the Fourteenth Amendment. This presents a jurisprudential problem: The very language of the Due Process Clause, which forbids the denial of life, liberty, or property *without* due process of law, necessarily implies that states *may* deny life, liberty, and property if due process of law is provided — unless some other provision of the Constitution is implicated. The notion of "substantive due process," as many distinguished commentators have pointed out, is an oxymoron — like "green pastel redness," in the famous comment of John Hart Ely. *Democracy and Distrust*, *supra*, at 18.

From the perspective of text and history, the Privileges or Immunities Clause of the Fourteenth Amendment would appear to

be a more plausible basis for the protection of substantive rights (whether incorporated from the Bill of Rights or based on other sources) than the Due Process Clause. See *id.* at 22; Philip B. Kurland, *The Privileges or Immunities Clause: "Its Hour Come Round At Last?"*, 1972 Wash. U. L. Q. 405, 419. It provides that "[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States." As discussed below, the language "privileges or immunities" was a legal term of art that also appears in the Comity Clause of Article IV, and that had been interpreted as referring to the essential rights and freedoms recognized in the American constitutional tradition.[18]

Why does this matter? Any constitutional jurisprudence of substantive rights, if conducted under the rubric of the Due *Process* Clause, must necessarily appear to be based on something other than constitutional text and the authentic purpose of the Fourteenth Amendment — indeed, such a jurisprudence will appear to have been created by judges with no delegation of constitutional authority by the people. Not only does this give the very idea of

[18] This would require reconsideration of the reasoning (though not necessarily the result) of the *Slaughter-House Cases*, 83 U.S. (16 Wall.) 36 (1873), which reduced this Clause to the redundancy of protecting only those rights already protected under the Constitution and arising as a matter of federal citizenship. But the overwhelming weight of historical and scholarly opinion is that *Slaughter-House* was wrong in this regard. See, *eg.*, Akhil R. Amar, *The Bill of Rights and the Fourteenth Amendment*, 100 Yale L. J. 1193, 1257-59 (1992); Raoul Berger, GOVERNMENT BY JUDICIARY: THE JUDICIAL TRANSFORMATION OF THE FOURTEENTH AMENDMENT 37-49 (1977); Michael Kent Curtis, NO STATE SHALL ABRIDGE: THE FOURTEENTH AMENDMENT AND THE BILL OF RIGHTS 175-77 (1986); John Harrison, *Reconstructing the Privileges or Immunities Clause*, 100 Yale L.J. 1385, 1466-69 (1992); Walter E. Murphy, Slaughter-House, *Civil Rights, and the Limits on Constitutional Change*, 1987 Am. J. of Jurisprudence 1, 1-8 (1987); William E. Nelson, THE FOURTEENTH AMENDMENT: FROM POLITICAL PRINCIPLE TO JUDICIAL DOCTRINE 156-64 (1988). A rare exception to this scholarly consensus is Robert Bork, THE TEMPTING OF AMERICA: THE POLITICAL SEDUCTION OF THE LAW 36-39 (1990).

For an explanation by the author of this brief of the reasons why *Slaughter-House* was inconsistent with the text and original meaning of the Fourteenth Amendment, see Michael W. McConnell, *Originalism and the Desegregation Decisions*, 81 Va. L. Rev. 947, 999-1000 (1995).

judicial protection of rights not specified by the text an undeserved aura of illegitimacy, it also — and more importantly — deprives us of a textual or historical basis for distinguishing between responsible and irresponsible exercises of that judicial power. Once it is recognized that the Privileges or Immunities Clause authorizes protection for rights *understood in a particular way*, there is a solid basis for distinguishing between legitimate and illegitimate uses of that power.

Although the Due Process Clause is essentially about process and the Privileges or Immunities Clause is essentially about substantive rights, the underlying principles and methodologies for application are consistent and complementary. The task of interpretation is greatly eased by the fact that each Clause had its counterpart in the Bill of Rights and Article IV, respectively, and each had been authoritatively interpreted at the time those terms were used in the new Fourteenth Amendment. When the framers of the Fourteenth Amendment used familiar legal terminology, it may be inferred that the terms were intended to be interpreted in light of then-prevailing doctrine.

The leading case interpreting the Privileges and Immunities Clause of Article IV in the years prior to the Civil War was *Corfield* v. *Coryell*, 6 Fed. Cas. 546 (1823), written by Justice Bushrod Washington on circuit. The court defined the privileges or immunities of citizens as consisting of:

> those privileges and immunities which are, in their nature fundamental; which belong, of right, to the citizens of all free governments; and which have, at all times, been enjoyed by the citizens of the several states which compose this Union, from the time of their becoming free, independent, and sovereign.

In other words, these "fundamental" rights[19] had two characteristics: (1) they were recognized by "all free governments,"

[19] It should be noted that the term "fundamental" rights did not necessarily mean rights that are especially important. Rather, in England, America, and western Europe, "fundamentality" most often referred to the character of being long-standing or ancient. See J.G.A. Pocock, THE ANCIENT CONSTITUTION AND THE FEUDAL LAW 30-36, 47-55 (1957); J.W. Gough, FUNDAMENTAL LAW IN ENGLISH CONSTITUTIONAL HISTORY 160 (1955).

and (2) they had been enjoyed by citizens "of the several states" from the beginning of the Republic. *Corfield* was repeatedly cited by proponents of the Fourteenth Amendment to explain what rights the new Amendment would protect.[20]

The leading case interpreting the Fifth Amendment Due Process Clause prior to the Civil War was *Murray's Lessee v. Hoboken Land and Improvement Co.*, 59 U.S. (18 How.) 272 (1856). In that case, Justice Benjamin Curtis (later to be the leading dissenter in *Dred Scott*) offered the following methodology for determining what "due process" entails in any particular case:

> We must examine the constitution itself, to see whether this process be in conflict with any of its provisions. If not found to be so, we must look to those settled usages and modes of proceeding existing in the common and statute law of England, before the emigration of our ancestors, and which are shown not to have been unsuited to their civil and political constitution by having been acted on by them after the settlement of this country.

In the first important due process case after ratification of the Fourteenth Amendment, *Hurtado* v. *California*, 110 U.S. 516 (1884), the Court reiterated this interpretation. This formulation suggests that due process embodies (1) explicit constitutional provisions, plus (2) long-established procedural rights ("modes of proceeding") that had existed in America from the beginning.

These two clauses of the Fourteenth Amendment thus have two common features. First, they take their bearings from the long-established rights and procedures of the American states. They are, accordingly, *preservative* rather than *transformative*. They are guarantees against unwarranted and unwise innovation; they are not invitations to judicially-mandated social change. This does not mean that the rights protected by these clauses are frozen in time. They may change as society changes. But before a claim may be accepted as a Fourteenth Amendment right, and imposed on the people of all the states, it must have withstood the test of time.

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[20] See, *e.g.*, Cong. Globe, 39th Cong., 1st Sess. 1835-36 (Apr. 7, 1866) (Rep. Lawrence); *id.* at 474-75 (Jan. 29, 1866) (Sen. Trumbull); *id.* at 2765 (May 28, 1866) (Sen. Howard).

The Fourteenth Amendment is not a license for judicial social experimentation.

Second, the two Clauses have the effect (as intended by the framers of the Fourteenth Amendment) of nationalizing the question of rights. Prior to the Fourteenth Amendment, the states were the principal locus of rights protection. Thus, the privileges and immunities of Americans were described in Article IV as "Privileges and Immunities of Citizens *in the several States*"; but in the Fourteenth Amendment these rights became known as "privileges or immunities of citizens *of the United States*." Moreover, under the new Amendment the power of the United States was deployed to prevent any state from abridging these rights, even as to its own citizens. Thus, the concept of rights became national. As John Bingham of Ohio, principal author of the Amendment, explained, it "protect[s] by national law the privileges and immunities of all the citizens of the Republic and the inborn rights of every person within its jurisdiction whenever the same shall be abridged or denied by the unconstitutional acts of any State." Cong. Globe, 39th Cong., 1st Sess. 2542 (1866).[21]

In practice, as interpreted by *Corfield*, *Murray's Lessee*, and *Hurtado*, this means that an individual may challenge the denial of any right that has been recognized by a sufficiently large number of states for a sufficiently long period of time that it can truly be said to be part of the fabric of American liberty. (Analogies might be drawn to the process of divining customary international law from the established practices of many states, or of determining the general common law in the period before *Erie R.R. Co.* v. *Tompkins*, 304 U.S. 64 (1938).)

In the years since *Corfield*, *Murray's Lessee*, and *Hurtado*, this Court has sometimes exceeded the authority implied by those cases, and has invalidated legislation without valid warrant in either express constitutional provisions or the settled judgment of the Nation. The most obvious examples are the decisions known as "the *Lochner* era." In other decisions, which have gained in respect

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[21] For further elaboration of this point, see Michael W. McConnell, *The Fourteenth Amendment: A Second American Revolution or the Logical Culmination of the Tradition?*, 25 Loy.-L.A. L. Rev. 1159, 1164-68 (1992).

and influence over the years, the Court has defined the reaches of unenumerated rights in terms not dissimilar to those in *Corfield*, *Murray's Lessee*, and *Hurtado*.

In his prescient dissent in *Lochner* v. *New York*, 198 U.S. 45, 76 (1905), Justice Holmes argued that instead of deciding the case on the basis of their own economic theories, the Justices should rely on "fundamental principles as they have been understood by the traditions of our people and our law." This approach was embraced by the Court in *Snyder* v. *Massachusetts*, 291 U.S. 97 (1934). In that case, Justice Cardozo explained that the Fourteenth Amendment protects rights "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Id.* at 105. See also *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923) (recognizing "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men"); *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (plurality by Powell, J.) ("the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition"); *Michael H.* v. *Gerald D.*, 491 U.S. 110 (1989) (plurality).

Perhaps the leading statement of this approach in the modern period was Justice Harlan's dissenting opinion in *Poe* v. *Ullman*, 367 U.S. 497, 542 (1961), later to form the basis for his opinion in *Griswold*:

> Due process has not been reduced to any formula; its content cannot be determined by reference to any code. The best that can be said is that through the course of this Court's decisions it has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. If the supplying of content to this Constitutional concept has of necessity been a rational process, it certainly has not been one where judges have felt free to roam where unguided speculation might take them. The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing.

Harlan did not engage in speculative inquiries about what freedoms he deemed most important to human life. Rather, he asked the concrete question: how has the asserted right been treated by the 50 states and by other nations? In the case of laws prohibiting the use of contraceptives, Harlan found "conclusive" the "utter novelty of this enactment." *Poe*, 367 U.S. at 554-55; see also *Griswold*, 381 U.S. at 499. Neither the federal government, any other state, nor any other nation, he found, "has made the *use* of contraceptives a crime." *Poe*, 367 U.S. at 554.

If Harlan's interpretive method departs from that in *Corfield*, *Murray's Lessee*, and *Hurtado*, it is solely in his emphasis on tradition as a "living" thing. It is not necessary, Harlan seems to be saying, that the tradition have existed unbroken from the time of the Founding. It is sufficient — as his analysis in *Poe* and *Griswold* bears out — that a substantial consensus of the states had recognized the right for a period long enough that it came to represent the will of the Nation.[22]

Harlan's central insight is that constitutional judicial review under the Due Process Clause *must not be based on the judges' own "unguided speculation."* Accord, *Casey*, 505 U.S. at 849 (the fact that the boundaries of substantive due process "are not susceptible of expression as a simple rule * * * does not mean that we are free to invalidate state policy choices with which we disagree"). The judges must, instead, seek the "balance" that "*our Nation*" has struck. This does not mean that judges are entitled to don the robe of the philosopher king and second-guess the decisions of legislatures. As in *Marbury*, there is no suggestion that the judges are superior to the people in their capacity to determine the proper restraints on government. The judges instead must enforce

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[22] The necessity of viewing tradition as a "living" thing was reaffirmed in *Burnham* v. *Superior Court*, 495 U.S. 604 (1990) (plurality per Scalia, J.). In *Burham*, the Court explained that when traditionally approved procedures have been abandoned by all but "a very small minority of the States," they become vulnerable to due process challenge, however "traditional" they may once have been, but where the challenged practice "is both firmly approved by tradition and still favored," it cannot be said to violate due process. *Id.* at 622; see also *id.* at 615 (noting that the challenged pracatice is "not only old; it is continuing").

the will of the people as it is reflected in the traditions which they have developed, as well as the traditions from which they broke.

This approach makes sense because judicial interpretations based on longstanding customs and practices are grounded — like the text of the Constitution itself — in the will of the people; because longstanding experience — in contrast to philosophical speculation — provides a sound empirical basis for reasoned judgment; and because the legal terms used by the framers of the Fourteenth Amendment were understood at that time to be references to long-established rights and privileges. The contrasting approach, adopted by the courts below, divorces itself from popular will, replaces the experience of history with judicial whim, and has no legitimate basis in the history and political theory of the Fourteenth Amendment.

B. The Abortion Cases Should Serve As A Cautionary Note Rather Than A Precedent

There is only one significant area in which this Court has departed from this approach to the Due Process Clause: the abortion cases. In *Roe* v. *Wade*, 410 U.S. 113 (1973), this Court struck down a state law prohibiting abortion notwithstanding the fact that such laws had been in place in at least 45 states for at least 100 years. The Ninth Circuit relied heavily on those cases. Pet. App. A25-A28, A56-A58.

Strictly as a matter of precedent, the Ninth Circuit's reliance was misplaced.[23] Essential to the holding of *Roe* was the conclusion that fetuses or unborn children are not constitutional "persons" and that their status as persons was beyond the ken of court or legislature. 410 U.S. at 158-59. By contrast, no one has questioned the indubitable fact that the patients involved in these cases are persons in every sense of the word. The *Roe* holding that fetuses, as non-persons, fall outside of the state's legitimate role of protection says nothing about the proper disposition of this case. Moreover, in the years since *Roe*, many commentators have come to the conclusion that the abortion right is more plausibly predicated on the fact that abortion laws bear most heavily on

[23] See generally Seth Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 Am. U. L. Rev. 803 (1995).

women and thus raise a problem of sex discrimination.[24] Whatever one may think of that argument, it has no application to these cases, which involve laws that potentially apply to every one of us, without distinction.

The Ninth Circuit found "highly instructive" and "almost prescriptive" (Pet. App. A57) language from the *Casey* plurality opinion that referred to "the most intimate and personal choices a person may make in a lifetime," and which stated: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.*, quoting *Casey*, 505 U.S. at 851. With all respect to the Ninth Circuit, those quotations will not bear the weight put on them.

Like other highly generalized formulations about liberty — for example, the "right to be left alone" — the statement in *Casey* cannot be understood literally, as "prescriptive" of specific rights. The statement is so general and abstract that it could mean anything or nothing. It surely does not mean that every intimate or personal choice is constitutionally protected. Rather, it must be read in the context of the opinion as a whole. In light of the plurality's emphasis on the "unique" character of the abortion decision (*id.* at 852), it is untenable to stretch these statements to cover the entirely different context of assisted suicide.

This Court has cited *Roe* in support of a new substantive due process right only once since *Roe* was decided 23 years ago, and that case was amply supported by traditional due process methodology. *Moore* v. *City of East Cleveland*, *supra*.[25] In the

[24] See, *e.g.*, Guido Calabresi, IDEALS, BELIEFS, ATTITUDES, AND THE LAW 99-102 (1985); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1199-1202 (1992); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. Rev. 375, 382, 386 (1985); Martha Minow, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW 56-60 (1990); Cass R. Sunstein, THE PARTIAL CONSTITUTION 270-85 (1993); Laurence H. Tribe, ABORTION: THE CLASH OF ABSOLUTES 105 (1990); see also Richard Posner, SEX AND REASON 339-40 (1992) (noting that the "focus" of *Roe*'s defenders has "shifted to the equal protection clause").

[25] *Roe* has been cited in several cases involving the right to contraceptives, but in light of *Griswold* these cannot be said to be new substantive due process rights. It has also been cited in several equal protection cases.

meantime, the Court has refused to recognize asserted rights to engage in acts of homosexual sodomy, of patients to choose their own form of medical treatment, of a father to enjoy visitation rights with his child born of an adulterous relationship, of prisoners to contact visits while in pretrial detention, of unrelated persons to share a home together, of a person to be free from governmental distribution of derogatory information about himself, of a psychiatric patient to be free from compulsory hospitalization, of an employee to be warned of workplace hazards, and of juvenile aliens to be placed in noncustodial settings. Far from suggesting that the abortion cases justify an expansion of substantive due process into other matters of great personal importance, these decisions show that the Court has been extraordinarily reluctant to extend the precedent. *Collins* v. *City of Harker Heights*, 505 U.S. 115, 125 (1992); *Reno* v. *Flores*, 507 U.S. 282, 302 (1993). This vitiates any plausible claim that the abortion precedents compel recognition of a right to assisted suicide.

More fundamentally, we submit that the abortion cases should not be treated as an unalloyed success, to be imitated in other areas of our national life. While this Court has decided to adhere to the fundamental holding of *Roe* for reasons of *stare decisis* and settled expectations (*Casey*, 505 U.S. at 854-69), it is apparent to many (even to supporters of the "right to choose") that the Court's sweeping decision, at one stroke, to invalidate the laws of almost every state on a matter that is deeply controversial among the people of this nation, was of questionable legitimacy and even more questionable prudence. Now, almost a quarter century after the *Roe* decision, the abortion question continues to be the most divisive in American politics, poisoning everything from presidential nominating conventions to the confirmation hearings of Supreme Court Justices. Many supporters of abortion rights believe that those rights would have been achieved with less contention and greater public acceptance if the matter had been left to the political process, as in other Western nations. There is no reason to repeat those mistakes in this context.

C. The Asserted Right To Assisted Suicide Is Not A Fundamental Right Under The Fourteenth Amendment

The decision of the Ninth Circuit is antithetical to the traditional approach outlined in *Corfield*, *Murray's Lessee*, and

Hurtado and articulated more fully by Justice Harlan. The claim of a right to assisted suicide may be a respectable philosophical position, but it has absolutely no foundation in the explicit provisions of the Constitution or in the balance "our Nation" has struck.

Assisted suicide is prohibited by statute in 35 states and by common law in 11 more.[26] In only one state, Oregon, is it expressly permitted, and then only recently. These laws reflect a longstanding common law tradition against allowing suicide in any form. Even the Ninth Circuit traces the common law prohibition of suicide to the 13th Century, acknowledges that the Western treatment of suicide as a crime persisted for 1,000 years, and admits that the medical ethical prohibition of assisting suicide dates to the time of Hippocrates. Pet. App. A44-A45, A94. The tradition embodied by these laws is — moreover — a "living" one. Nine states have strengthened their statutory prohibitions in the past five years.[27] State legislatures in an additional 15 states[28] have debated the issue since 1991, and all have decided to retain their laws. Referenda proposing legalization of assisted suicide have been rejected by the voters of California and Washington (though accepted by the voters of Oregon). The courts of at least 17 states, interpreting their common law, have distinguished assisted suicide

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[26] Citations to these statutes and decisions may be found in footnotes 12, 13, and 14 of the *Brief Amicus Curiae on Behalf of Members* of the New York and Washington State Legislatures.

[27] 720 Ill. Comp. Stat. Ann. § 5/12-31(a)(2) (effective Aug. 29, 1993); Ind. Code Ann. § 35-42-1-2.5(b) (approved Apr. 30, 1993); Iowa Code § 707A.2 (approved Mar. 1, 1996); 1994 Ky. Acts, ch. 269, § 2 (effective July 7, 1994); La. Rev. Stat. Ann. § 14:32.12 (effective June 16, 1995); Mich. Comp. Laws Ann. § 752.1027 (effective Mar. 31, 1993); N.D. Cent. Code § 12.1-16-04 (effective July 1995); R.I. Gen. Stat. tit. 11, § 60 (approved 1996); Tenn. Code Ann. 39-13-216 (approved 1993).

[28] Alaska, Arizona, California, Colorado, Connecticut, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Vermont, Washington and Wisconsin.

from the established right to refuse treatment.[29] The American Medical Association, the American Geriatric Society, the American Psychological Association, and the American Bar Association, have all debated the issue in recent years and declined to endorse legalization. Interdisciplinary task forces in New York and Great Britain have unanimously voted to retain laws against assisted suicide. The drafters of the Model Penal Code retained prohibitions against assisted suicide without any exceptions. MODEL PENAL CODE § 210.5(2) (Official Draft and Revised Comments 1980). The Supreme Court of Canada has rejected an asserted right to assisted suicide. *Rodriguez* v. *British Columbia (Attorney General)*, [1993], 3 S.C.R. 519. No unreversed courts — other than the courts below — have ever accepted such a claim.

In the face of this nearly unanimous tradition, which enjoys considerable support to this day, it is simply disingenuous to claim that assisted suicide reflects the balance that "our Nation" has struck. It represents nothing other than the balance that the judges on the Ninth and Second Circuits have struck. See *Reno* v. *Flores*, 507 U.S. at 303 (citations omitted) ("The mere novelty of such a claim is reason enough to doubt that 'substantive due process' sustains it; the alleged right certainly cannot be considered 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'").

The Ninth Circuit opinion is virtually a parody of proper constitutional analysis under the Fourteenth Amendment. In contrast to Justice Harlan's insistence that rights must be grounded in historical experience, the Ninth Circuit declared that "earlier legislative or judicial recognition of the right or interest is not a sine qua non" (Pet. App. A35). Remarkably, in its survey of "Historical Attitudes Toward Suicide," the court below disregarded unbroken and virtually unanimous state practice in favor of a combination of inapposite ancient views and modern polling data. The court began with "ancient attitudes," in which suicide "was

[29] Citations may be found in the *Brief Amicus Curiae on Behalf of Members* of the New York and Washington State Legislatures, at 24-27 & n.25.

often considered commendable." Pet. App. A40.[30] The court was unperturbed by the fact that, by its own evidence, suicide was commended in cases of dishonor, grief, guilt, and weariness of life. Pet. App. A40-A42; see also *id.* at A41 ("The Stoics glorified suicide as an act of pure rational will."). Since not even the Ninth Circuit thinks we should go that far, this glorification of suicide would appear to be a tradition from which we have broken, rather than one that reflects "our Nation's" balance between liberty and the demands of organized society. It is a strange basis for saying that modern statutes, reflecting the modern respect for life, are unconstitutional.

After devoting several paragraphs to the early Christian martyrs (who did not commit "suicide" as it is ordinarily understood, but simply worshipped God and paid the price), the court grudgingly acknowledged — *in one clause of one sentence* — that the "view that suicide was in all cases a sin and crime held sway for 1,000 years" (Pet. App. A44). The court moved quickly to the more convenient fact that some "philosophers, poets, and even some clergymen" began to dissent in the 17th century. *Id.*

[30] Although space will not permit us to engage in a debate with the court below over its reading of historical sources, the observant reader cannot fail to notice the one-sided and selective nature of the court's account. For example, the court invoked the distinguished name of Plato in support of the practice of suicide, (Pet. App. A41), but failed to mention that Aristotle, no less impressive an authority, took the view that suicide was unjust under all circumstances. Aristotle, NICOMACHEAN ETHICS, chap. 5, 1138a. Similarly, while the court's statement that suicide was not "universally prohibited" in Greek times and was sometimes "considered commendable" (Pet. App. A40) is literally true, it might have been more balanced to acknowledge that, according to the historian on whom the court relied, suicide was generally disfavored, and euthanasia was not practiced. A. Alvarez, THE SAVAGE GOD 58 (1971), discussed in the NEW YORK REPORT, at 78 & n.5. Most strikingly, the court cited seven poets and philosophers of the early modern period who "challenge[d] the all-encompassing nature of the dominant ideology" (Pet. App. A44) — failing to mention that such luminaries as John Locke and Immanuel Kant (among others) defended the traditional ban on suicide. See NEW YORK REPORT, at 81.

In short, while the Ninth Circuit's historical survey is not literally inaccurate, its selective use of evidence seems designed to suggest that suicide enjoyed more support in past ages than it actually did. The court's pejorative reference to "the dominant ideology" (Pet. App. A44) effectively concedes that the anti-suicide tradition was, in fact, "dominant."

The court also drew comfort from the fact that, on the eve of the Reign of Terror, the revolutionary regime in France legalized suicide. *Id.*

Unable to gainsay the common law prohibition of suicide, which dates from at least the 13th century and was endorsed by some of the greatest figures in English legal history, the Ninth Circuit attributed this legal norm to "taboos" and to "the ancient fear that the spirit of someone who ended his own life would return to haunt the living." Pet. App. A46. The court then made much of the decriminalization of suicide in the last century (Pet. App. A46-A47), without pointing out that the reason for this was that punishment was deemed an inappropriate social response. See e.g., *State* v. *Marti*, 290 N.W.2d 570, 581 (Iowa 1980) ("The only reason we view suicide [as] noncriminal is that we consider inappropriate punishing the suicide victim or attempted suicide victim, not that we are concerned about that person's life any less than others' lives); *Commonwealth* v. *Mink*, 123 Mass. 422, 429 (1877) (repeal of sanctions for suicide "may well have had its origin in consideration for the feelings of innocent surviving relatives"); Testimony of Prof. Victor Rosenblum, HOUSE HEARINGS, at 283.

As noted, 46 states now prohibit assisted suicide, and many of those prohibitions are the product of recent deliberation. The Ninth Circuit gives no weight to this legislative record. Instead, the court cites public opinion polls that, according to the court, show popular support for a change in the laws. Pet. App. A48-A49. Incredibly, the court draws further support from the fact that, while voters rejected assisted suicide in referenda in California and Washington, the votes were close. The court's infatuation with polling data extends even to professional opinion, since the court relied on polls purporting to show that physicians support assisted suicide — (*id.* at A92-A93) — even though their professional organizations are formally on record as opposing it and the precepts of medical ethics forbid it.

It hardly needs be said that constitutional law should not be governed by public opinion polls. We doubt seriously that the Ninth Circuit would be greatly impressed by polls showing overwhelming support for school prayer, capital punishment, or laws against flag burning. We think it is far more significant that

every time the question of assisted suicide is subjected to *reasoned deliberation* — whether by legislature or by commission — the wisdom of the traditional prohibition is reaffirmed.

Putting aside its incursion into selective ancient history and its opportunistic invocation of opinion polls, the Ninth Circuit has literally *no support* for its conclusion that the right to assisted suicide is grounded in this nation's history or tradition.

To affirm the decision below would require an extraordinary transformation of constitutional principles. Since the decision has no basis in constitutional text, no basis in original understanding, no basis in the traditions of the nation, no basis in the protection of a discrete and insular minority, and no real basis in precedent, affirmance would stand for the bald proposition: the Constitution authorizes courts to invalidate laws simply on the basis that the judges disagree with them. These cases present an ideal opportunity for the Court to reassure this Nation that the judiciary does *not* purport to exercise such a power.

CONCLUSION

The decisions of the courts below should be reversed.

Respectfully submitted.

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OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF AMICUS CURIAE OF THE CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the New York and Washington statutes prohibiting physician assistance in suicide violate either the Due Process Clause or the Equal Protection Clause of the Fourteenth Amendment.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

No. 96-110

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF AMICUS CURIAE OF THE CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

The Catholic Medical Association ("CMA") is a non-profit, public service organization founded in 1932. The CMA promotes the principles of Roman Catholic medical ethics in science and in the practice of medicine. The

CMA includes more than one thousand physicians and coordinates the activities of more than 80 regional Catholic physicians' guilds in the United States and Canada.[1]

Since 1932, the CMA has published *The Linacre Quarterly*, a leading scholarly journal on biomedical ethics. The CMA's companion Linacre Institute routinely produces studies on important medical and moral issues. The CMA also serves as a resource for the medical community, holding annual conferences where scholars and health care professionals meet and interact.

The CMA, as an *amicus curiae* before this Court, seeks to contribute its professional and ethical perspective on physicians and their role in treating the terminally ill. Since its inception, the CMA has brought the practical experience and scholarly expertise of its members to bear on important societal issues. The CMA wishes to share with this Court the insights of the scholars and physicians that are its practicing members.

In addition to its own experience, the CMA hopes to inform the Court of a central theme in Catholic medical ethics, the distinction between meeting death with peace and dying at one's own hand.

For decades, Catholic religious and medical leaders have differentiated between suicide and the forgoing of life support. In rejecting such a distinction, the Second and Ninth Circuits broke from a venerable historical tradition. As a unique part of that tradition, the CMA asks the Court to consider its arguments in support of the Petitioners.

SUMMARY OF ARGUMENT

A right to give or receive assistance in suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this Nation's history and tradition. Other than the Ninth Circuit in its decision below, every court that

[1] The parties in both *Vacco* and *Glucksburg* have consented to the filing of this brief. The parties' letters of consent have been submitted to the Clerk of the Court.

has considered physician assisted suicide has concluded that there is no such right. Indeed, even the Second Circuit, which invalidated New York's prohibition of assistance in suicide on equal protection grounds, concluded that such a right "finds no cognizable basis in the Constitution's language or design."

Respondents claim that assisted suicide involves a decision concerning one's own body and that, as such, it falls within the realm of personal liberty that government may not enter. But the concept of ordered liberty under the Due Process Clause does not equate with unrestrained autonomy, and this Court has never endorsed demands to assist those who would make seemingly personal choices that diminish their own lives or the common good.

A right to assisted suicide finds no support in this Nation's history and tradition. At common law, a person who assisted another to commit suicide was guilty of murder. At the time of the Fourteenth Amendment, the vast majority of states explicitly prohibited assisted suicide. Even today, forty-five states continue to criminalize the practice. *See* Appendix C.

Weighing against any interest in assisted suicide is the State's compelling interest in protecting, indeed its obligation to protect, the lives of its citizens. Given the origins of government, and the nature of the bargain between the State and its citizens, the State has an obligation to protect life simply because of its existence. This obligation does not vary with the circumstances of particular citizens, but applies to all persons under the State's authority and protection. In rejecting society's obligation to protect the lives of all its citizens, the Ninth Circuit erred.

The Second Circuit similarly erred in concluding that New York's prohibition against assistance in suicide violates the Equal Protection Clause. Although the Constitution requires that all persons similarly situated should be treated alike, the Constitution does not require things

that are different to be treated as though they were the same. Physician assisted suicide is fundamentally different from forgoing medical treatment because, unlike forgoing medical treatment, assisted suicide always involves an intent to kill. In confusing the distinction between knowledge and intent, the courts of appeals rejected the common-sense notion that one may choose to forgo disproportionately burdensome medical treatment and at the same time retain a strong desire to live. Unlike some who choose to forgo medical treatment, however, those who engage in assisted suicide have death as their purpose. Such a distinction based on intent more than satisfies the constitutional requirement of rationality and non-arbitrariness.

ARGUMENT

The Declaration of Independence states that it is "self-evident" that all men "are endowed by their Creator with certain unalienable Rights," and that among these rights are "Life, Liberty, and the Pursuit of Happiness." It is no accident that life is listed first. The Due Process Clause in the Fifth and Fourteenth Amendments also puts life first: No person shall be deprived of "life, liberty, or property, without due process of law . . . ." The reason for this ordering is apparent. Without life, there can be no other rights. As Justice Holmes said, "[l]ife is an end in itself, and the only question as to whether it is worth living is whether you have enough of it." [2]

Societies throughout history, including our own, have recognized life and its protection as an unqualified good, indeed, as *the* good from which other societal goods derive.[3] Physicians serve society by maintaining life, by

[2] Oliver Wendell Holmes, Jr., Speech to the Bar Association of Boston (Mar. 7, 1900) *in* Collected Legal Papers 244, 248 (1920).

[3] Society's unqualified commitment to life runs throughout traditional jurisprudence. In *Blackburn v. State*, 23 Ohio St. 146, 163 (1872), for example, the Ohio Supreme Court observed that:

> [T]he life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Accord, 4 William Blackstone, *Commentaries on the Laws of England* *189 ("The suicide is guilty of [an offense] against the King, who hath an interest in the preservation of all his subjects"). Similarly, this Court has acknowledged the constitutionality of such a fundamental choice for life:

> [W]e think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . .

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 282 (1990). *See also* Pope John Paul II, Encyclical Letter *Evangelium Vitae* ¶ 66 (March 25, 1995) (noting that life is God's gift and that suicide is a rejection of that gift); *accord*, 1 William Blackstone, *Commentaries on the Laws of England* *125 ("Life is the immediate gift of God, a right inherent by nature in every individual").

healing patients who request their help, and by promoting health, which is fundamental to the enjoyment of so many of life's virtues. Conversely, American society has always condemned physicians who stray from the healing path, who use their knowledge to harm, or who fail to fulfill their role as guardians of society's interest in life.[4]

The decisions here under review depart from the traditional, and salutary, emphasis on the protection of life. In invalidating New York and Washington State's prohibitions against assisted suicide, the Second and Ninth Circuits erred because: (1) a right to assisted suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this Nation's history and tradition; (2) permitting assisted suicide cannot be reconciled with gov-

[4] *See, e.g., United States v. Brandt (the Medical Case)*, II Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10, at 181 (1949); *see also United States v. Stanley*, 483 U.S. 669, 708 (1987) (O'Connor, J., concurring in part and dissenting in part).

ernment's obligation to protect the lives of the governed; and (3) assisted suicide differs fundamentally from forgoing medical treatment, because assisted suicide, by definition, involves an intent to kill.

I. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE DUE PROCESS CLAUSE BECAUSE SUCH PROHIBITIONS FURTHER SOCIETY'S UNQUALIFIED INTEREST IN LIFE.

This Court understandably has been "reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights,* 503 U.S. 115, 125 (1992). As the Court itself has explained, "[t]he Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. . . . There should be, therefore, great resistance to expand the substantive reach of [the Due Process] Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority." *Bowers v. Hardwick,* 478 U.S. 186, 194-95 (1986).

Such concerns are no less apt in the area of physician assisted suicide, where "[b]road policy questions bearing on life and death issues are more properly addressed by representative assemblies." *See Cruzan v. Harmon,* 760 S.W.2d 408, 426 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261 (1990). As Judge Kleinfeld wrote in dissent in this case, "[t]he Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all the great questions would be decided by the judiciary." Glucksberg App. at 161-62.

Because of the potentially boundless nature of substantive due process claims, this Court, in reviewing such

claims, has stressed the importance of carefully describing the asserted right and the legal issue that the Court is being asked to decide. *See, e.g., Planned Parenthood v. Casey,* 505 U.S. 833, 847-48 (1992); *Michael H. v. Gerald D.,* 491 U.S. 110, 118-30 (1989). In the Court's words, " '[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.' " *Reno v. Flores,* 507 U.S. 292, 302 (1993) (citations omitted). Interests for which constitutional protection is sought "cannot be described merely at the level of philosophic abstraction . . . ." Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still A Wonderful Life?,* 70 Notre Dame L. Rev. 519, 559 (1995). It is critical to determine precisely what right is being asserted when statutes like those at issue here are said to violate the Due Process Clause. It is also important to inquire whether any other due process interests would be implicated if this Court were to recognize the claimed physician's right to assist in suicide.

A. A Right to Give or Receive Assistance in Suicide Is Neither Implicit in the Concept of Ordered Liberty, Nor Deeply Rooted in This Nation's History and Tradition.

Respondents assert a right, under certain circumstances, intentionally to terminate the life of a human being—a human being that the law regards as innocent of any offense. This case does not involve society's imposition of death as a sanction for some heinous wrong. Rather, it involves an alleged constitutional right to intervene to introduce a new causative factor, one which, in the absence of the intervention, would play no role in bringing about the patient's death. The Ninth Circuit failed to appreciate the significance, for constitutional purposes, of such intentional causation of death through the deliberate introduction of a poisonous drug or other lethal substance. The

court focused incorrectly on the end—death—rather than on the means by which that death occurs. In the court's words, "it is the end and not the means that defines the liberty interest."[5] By concentrating on the abstract "right to die," the court obscured meaningful practical and constitutional distinctions:

> [W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . *To us, what matters is that the death is the intended result as surely in one case as in the other.*

Glucksberg App. at 82 (emphasis supplied).

This Court, however, historically has afforded protection only to those interests "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937), *quoted in Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986). In an alternative formulation, this Court has described those interests entitled to constitutional protection as ones "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977).

Other than the Ninth Circuit in the decision below, every court that has considered physician assisted suicide has concluded that "the right to commit suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this nation's history and tradition. It would be an impermissibly radical departure from existing tradition, and

[5] Glucksberg App. at 27. In response to similar arguments nearly seventy years ago, Justice Brandeis issued his famous warning:

> To declare that in the administration of the criminal law the end justifies the means . . . would bring terrible retribution. Against that pernicious doctrine this Court should resolutely set its face.

Olmstead v. United States, 277 U.S. 438, 468 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347 (1967).

from the principles that underlie that tradition, to declare that there is such a fundamental right protected by the Due Process Clause." *See, e.g., People v. Kevorkian*, 447 Mich. 436, 481, 527 N.W.2d 714, 732 (1994), *cert. denied*, 115 S. Ct. 1795 (1995). Even the Second Circuit, which invalidated on equal protection grounds New York's prohibition against assistance in suicide, concluded that "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death." Vacco App. at 19a.[6]

The concept of ordered liberty under the Due Process Clause does not equate with unrestrained autonomy. For example, this Court has never held that the Constitution confers an absolute right to do as one pleases with one's own body. *See, e.g., Roe v. Wade*, 410 U.S. 113, 154 (1973) (refusing to recognize such a right). Thus, a person has a right to refuse medical treatment, but no right to refuse vaccination from contagious disease. *See Washington v. Harper*, 494 U.S. 210, 222 (1990); *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27 (1905) (rejecting autonomy right in favor of the common good). A person has a right to marry, but no right to marry his or her blood relatives. A person has a right to direct the upbringing of his or her children, but no right to expose them to deadly harm. *See Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). "The statute books are replete with constitutionally unchallenged laws against prostitution, suicide, voluntary self-mutilation, brutalizing 'bare fist' prize fights, and duels, although these crimes may only directly involve 'consenting adults.'" *Paris Adult*

[6] Courts from other common law jurisdictions have reached similar conclusions. The Supreme Court of Canada, for example, has rejected a claim that Section 7 of the Canadian Charter of Rights and Freedoms, similar in scope to the Due Process Clause, establishes a fundamental right to physician assisted suicide. *See generally Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (Can. 1993).

Theatre I v. Slaton, 413 U.S. 49, 68 n.15 (1973). In each of these instances, claims for individual autonomy must be balanced against, and sometimes subordinated to, the common good. Indeed, the law has always acted to restrain choice that harms individual persons. Because we are a society that "strongly affirms the sanctity of life," [7] this Court has never endorsed demands to assist those who would make seemingly personal choices that diminish their own lives or the common good.

Respondents, however, maintain that "there is a realm of personal liberty which the government may not enter." Glucksberg et al., Opposition to Petition for Writ of Certiorari at 12. They further argue that this Court's precedent in the area of reproductive choice "acknowledge[s] that *decisions concerning one's own body*, one's own medical care, and one's own future life course fall within that realm." *Id.* (emphasis supplied). Yet, this Court has routinely rejected such an expansive view of personal autonomy, holding that there is no "*unlimited right to do with one's body as one pleases.*" *Roe*, 410 U.S. at 154 (emphasis supplied); *see also Bowers*, 478 U.S. at 191; *Slaton*, 413 U.S. at 68.

A due process right to physician assisted suicide also remains unsupported by this nation's history and tradition. "At common law suicide was a felony, punished by forfeiture of property to the king and ignominious burial. . . . Essentially, suicide was considered a form of murder." *In re Joseph G.*, 34 Cal. 3d 429, 433, 194 Cal. Rptr. 163, 165 (1983) (citations omitted). In the United States, most jurisdictions today regard suicide as "an expression of mental illness" or depression.[8] *Id.* Further, at common law, a person who assisted another to commit suicide was guilty of murder. *In re Joseph G.*, 34 Cal. 3d at 434, 194 Cal. Rptr. at 165. Perhaps most telling is the fact that "[a]t the time the Fourteenth Amendment was ratified, at least twenty-one of the thirty-seven existing states (including eighteen of the thirty ratifying states) proscribed assisted suicide either by statute or as a common-law offense." *Kevorkian*, 447 Mich. at 478, 527 N.W.2d at 731. Indeed, in *Cruzan*, Justice Scalia concluded that " 'there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.' ' " *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citations omitted). Of course, if there is no liberty interest to commit suicide, there can be no liberty interest in receiving the assistance of another to do so. *Kevorkian*, 447 Mich. at 468 n.35, 527 N.W.2d at 726 n.35.

Respondents and the Ninth Circuit attempt to avoid this historical consensus in two ways. First, they question the continued vitality of this Court's reasoning in *Palko v. Connecticut* and *Moore v. East Cleveland*. *See, e.g.*, Glucksberg App. at 55 (suggesting that *Palko's* actual language results in too strict a test); Glucksberg et al., Brief of Appellees in the Ninth Circuit at 27 n.29 (arguing that, instead of *Palko's* ordered liberty test, the Ninth Circuit should look to the "conscience of the people").

Instead of looking to *Palko* and *Moore*, respondents extract certain language from this Court's decision in *Casey* to formulate a new general test for evaluating rights under the Due Process Clause. In *Casey*, the Court stated that "[t]hese matters, involving the most intimate

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[7] *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring).

[8] The medical literature amply supports such conclusions. "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 11 (May 1994). Further, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.* at 13.

and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851. On the basis of this language, respondents identify any issue potentially important to personal dignity as a liberty interest, and then inquire whether, under a balancing test, that interest has been burdened by state action. *See, e.g.*, Glucksberg App. at 54-62.

Respondents' approach reads far too much into a single excerpt from the opinion in *Casey* and ignores the context in which that statement was made. *Casey* did not purport to engage in a fresh due process inquiry; indeed, as the plurality opinion demonstrates, a woman's right to choose an abortion was explicitly retained based on the settled expectations of *stare decisis*. *Casey*, 505 U.S. at 871. *Casey*, therefore, is an inappropriate tool to use as a lever to expand the limits of this Court's previously settled due process jurisprudence. Moreover, this Court's abortion cases in general, and the *Casey* opinion in particular, should not be used to draw general conclusions about the Due Process Clause outside the abortion context. Instead, as the Court has observed, "[a]bortion is a *unique* act. [In abortion,] . . . the liberty of the woman is at stake in a sense unique to the human condition and so *unique* to the law." *Id.* at 852 (emphasis supplied).

The Ninth Circuit's opinion below also attempts to avoid the historical consensus on assisted suicide by augmenting history. Although acknowledging society's historic opposition to assisted suicide, the Ninth Circuit refers to a supposedly "strong undercurrent of a time-honored but hidden practice" of assisted suicide that runs "beneath the official history of legal condemnation of physician-assisted suicide." Glucksberg App. at 51. This approach, however, fundamentally misapplies the reasoning of *Moore v. East Cleveland*, by giving preference to

an esoteric historical account over innumerable public acts rejecting the practice of assisted suicide.[9]

B. The State Has a Compelling Interest in Protecting, and Indeed an Obligation to Protect, the Lives of Its Citizens.

Even if this Court were to recognize some protected interest in giving or receiving assistance in suicide, that would not end the matter. The Court would need also to consider a State's compelling interest in protecting—indeed, the State's obligation to protect—the lives of its citizens.

As John Locke wrote, the "great and chief end" of those who "seek out and [are] willing to join in society" is "the *mutual* preservation of their lives." John Locke, *Two Treatises on Government* 350 (Peter Laslett ed. 1988) (emphasis supplied).[10] For Locke, and for the Framers of our Constitution, human beings come together in free society, consent to be governed, and, in return, receive a covenant from government that each citizen's life will be protected equally and unqualifiedly before the law. *Id.* As this Court has held, that covenant applies broadly to:

> all the powers of government, legislative as well as executive and judicial. It necessarily happened, therefore, that as these broad and general maxims of liberty and justice held in our system a different place and performed a different function from their position and office in English constitutional history and law, they would receive and justify a corresponding and more comprehensive interpretation. Applied in England only as guards against executive usurpation and

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[9] Perhaps mindful of the implausibility of its own historical account, the Ninth Circuit also refers to what it terms "drastic changes" in the public's recent attitudes toward physician assisted suicide. Glucksberg App. at 77.

[10] Locke was a staunch opponent of suicide, regarding it as the duty of each citizen "not to quit [one's] station willfully." John Locke, *Two Treatises on Government* 271 (Peter Laslett ed. 1988).

> tyranny, here they . . . must be held to guaranty not particular forms of procedure, but the very substance of individual rights to life, liberty, and property.

Hurtado v. California, 110 U.S. 516, 531 (1884).

Given the origins of government, and the nature of the bargain between the State and its citizens, the State has an obligation to protect life simply because of its existence, apart from any other consideration. This obligation does not vary with the circumstances of particular citizens but applies to all persons under the State's authority. As the Ohio Supreme Court wrote not long after the adoption of the Fourteenth Amendment:

> The life of those to whom life has become a burden —of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Blackburn v. State, 23 Ohio St. 146, 163 (1872); *accord*, *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring).[11]

Both history and tradition support the State's obligation to protect life and the citizen's right to expect such protection. Ever since the founding of the Republic, we have been a nation that "strongly affirms the sanctity of life." *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan,

[11] This principle runs throughout Catholic medical ethics as well. Indeed, the Catholic Church has always taught that "[t]he inviolability of human life means and implies in the last analysis the illicitness of every act which directly suppresses human life. 'The inviolability of the right to life of the innocent human being from conception to death is a sign and a requirement of the very inviolability of the person, to whom the Creator has given the gift of life.'" Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 136 (Boston: Daughters of St. Paul 1995), *quoting* Sacred Congregation for the Doctrine of the Faith, Instruction *Donum Vitae*, *in* 80 Actus Apostolicae Sedes 75-76 (1988).

J., concurring). "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280. As the British House of Lords recently concluded, this fundamental proposition is shared by all common law countries and is expressed in:

> society's prohibition of intentional killing. *That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all [lives] are equal.*

Select Committee on Medical Ethics of the House of Lords, *Report of the Select Committee on Medical Ethics* 48 (Jan. 1994) (emphasis supplied).[12]

Physician assisted suicide always involves the taking of human life, and, as such, permitting it would run counter to the State's fundamental obligation to protect its citizens. To be sure, physician assisted suicide advocates, including respondents, seek to limit the practice to certain narrowly defined circumstances, such as where a person is both terminally ill and mentally competent.[13] *See, e.g.*, Glucksberg App. at 9-11. All such proposed limitations, how-

[12] The House of Lords went on to apply this "cornerstone of law" to physician assisted suicide and euthanasia. It concluded that, "[w]e do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia." Select Committee on Medical Ethics of the House of Lords, *Report of the Select Committee on Medical Ethics* 48 (Jan. 1994).

[13] If this Court were to find a right to physician assisted suicide, it is by no means certain that such a right could be limited to the terminally ill. At least one lower court has held that any such limitation would violate the Equal Protection Clause. *See generally Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal docketed*, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949 (9th Cir. Aug. 7, 1995).

ever, necessarily rest on a judgment about quality of life. Such judgments are foreign to this Court's jurisprudence.

In *Cruzan*, this Court held that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . ." *Cruzan*, 497 U.S. at 282. Indeed, the risk in making such decisions about quality of life is great. As the Missouri Supreme Court noted in *Cruzan*, "[w]ere quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). Not surprisingly, the disabled count themselves among the strongest opponents of physician assisted suicide, which they regard as "based on erroneous judgments concerning the quality of life of a person with a disability or on social judgments that such a person's continued existence will impose an 'unacceptable' burden on his or her family or on the Nation as a whole. These judgments are often grounded in misinformation, inaccurate stereotypes, and negative attitudes about people with disabilities." United States Commission on Civil Rights, *Medical Discrimination Against Children with Disabilities* 12 (1989).

This Court itself has previously declined to differentiate among the due process rights of individuals based on their quality of life. In *United States v. Rutherford*,[14] terminal cancer patients sued to overturn the FDA's decision that Laetrile was not "safe and effective" within the meaning of the Food, Drug, and Cosmetic Act.[15] They sought, in effect, to substitute their judgment for that of the medical community about what might improve their quality of life.

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[14] 442 U.S. 544 (1979).

[15] 21 U.S.C. §§ 201, 355 (1996).

The terminally ill plaintiffs in *Rutherford* convinced a lower court that they had a due process right to choose even potentially unsafe and ineffective drugs because of their diminished quality of life.[16] Plaintiffs argued that the definition of safe and effective medical care had to be modified because their lives, which were of presumably limited duration, were entitled to a lesser degree of governmental protection.[17] This Court refused to recognize any dilution of due process based on quality of life. *Rutherford*, 442 U.S. at 555, 559. Although *Rutherford* ultimately was resolved on statutory grounds, it illustrates the caution with which courts should approach arguments based on diminished quality of life. *Id.*

Even if the Court were inclined to recognize some protected interest in suicide or assisted suicide, therefore, it should also recognize a fundamental obligation on the part of the State to protect the lives of its citizens. Allowing physician assisted suicide is incompatible with that obligation. As one medical organization recently observed, physician assisted suicide involves:

> *the deliberate taking of human life [and] should remain a crime.* This [Association's] rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. *It is instead an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.*

British Medical Association, *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* 69 (1988).[18]

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[16] *Rutherford v. United States*, 438 F. Supp. 1287, 1298-1301 (W.D. Okla. 1977).

[17] *Rutherford*, 442 U.S. at 551.

[18] Confirming the existence of a fundamental governmental obligation to protect the lives of its citizens would *not* require this Court

II. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE EQUAL PROTECTION CLAUSE BECAUSE, UNLIKE FORGOING MEDICAL TREATMENT, ASSISTED SUICIDE ALWAYS INVOLVES AN INTENT TO KILL.

Although the Equal Protection Clause requires that "all persons similarly circumstanced should be treated alike, . . . [t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (internal quotations and citations omitted). Instead, disparate treatment normally will pass equal protection scrutiny if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985).

The Second Circuit invalidated New York's prohibition against physician assisted suicide, reasoning that a state may not allow a terminally ill patient to hasten his or her death by forgoing life support and, at the same time, prevent a physician from dispensing lethal drugs to a terminally ill patient who wishes to use them to commit suicide. Vacco App. at 29a-30a. The Second Circuit based its holding on the premise that forgoing medical treatment and assisted suicide are indistinguishable. Vacco App. at 30a-31a. The Second Circuit failed to recognize, however, that physician assisted suicide always involves an intent to terminate a life, while forgoing medical treatment does not. The court also disregarded legitimate state interests supporting New York's prohibition of physician assisted suicide.

to reexamine any of its prior decisions. A person can forfeit either liberty or life through wrongdoing or malfeasance. That fact does not diminish the importance of those rights any more than the fact that there are inmates in our prisons calls into question the inalienability of the rights Jefferson declared.

Nor is there any inconsistency with this Court's decisions in *Casey* and earlier cases dealing with abortion. This Court has held that abortion does not extinguish the life of a "person" for purposes of the Fourteenth Amendment. *Roe*, 410 U.S. at 153 ("The word 'person,' as used in the Fourteenth Amendment, does not include the unborn"). Even so, it is well-settled that the States at least have "legitimate interests from the outset of the pregnancy in protecting . . . the life of the fetus that may become a child." *Casey*, 505 U.S. at 846.

The moral, civil, and common law has always regarded the refusal or withdrawal of medical treatment as fundamentally different from suicide.[19] There is, moreover, an obvious common-sense basis for this distinction. According to the American Bar Association, decisions to refuse treatment are "legally and ethically distinct" from decisions to administer "a lethal agent with the intentional purpose of terminating life." American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (1992). Assisted suicide "involves not letting the patient die, but making the patient die . . . ." Stephen L. Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* 236 (1993).

The difference between forgoing medical treatment and assisted suicide centers on the *mens rea* necessarily involved. According to one commentator:

> The definition of *suicide requires that one's actions be carried out for the purpose of bringing about death either as an end or as a means.* The soldier who throws himself on the live grenade to save his companions, for example, is not aiming at death. That is, he does not intentionally jump on the grenade for the purpose of bringing about his death, but rather for the purpose of saving his companions. This is clear if one considers that, if he lives and his companions are saved, then he would have achieved his purpose without dying. For this reason, his act is

[19] *See* Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 753-60 (1995); Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1, 9-13 (1985).

> not counted as suicide. On the other hand, consider the man who kills himself so his family can enjoy the proceeds from his life insurance. Clearly, he intentionally carries out his actions for the purpose of bringing about death. He is aiming at his death, albeit as a means to another end: if he lives, he would have failed in his purpose since, without his death, no inheritance will be forthcoming.

Manual G. Velasquez, *Defining Suicide,* 3 Issues L. & Med. 37, 49 (1987) (emphasis supplied). Assisted suicide, therefore, necessarily involves an intent to kill. Patients, on the other hand, can forgo medical treatment without such an intent. Indeed, they may act:

> in order to safeguard themselves at the point of death against "the use of techniques that run the risk of becoming abusive." Contemporary Medicine in fact, has at its disposal methods which artificially delay death, without any real benefit to the patient. It is merely keeping one alive or prolonging life for a time, at the cost of further, severe suffering. This is so-called "therapeutic obstinacy," which consists "of the use of methods which are particularly exhausting and painful for patients, condemning them, in fact, to an artificially prolonged agony."

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 119 (Boston: Daughters of St. Paul 1995), *quoting* Pope John Paul II, *Address to the Participants at the International Congress on Assistance to the Dying, in* OssRom, Mar. 18, 1992. at 65 n.4; and Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 549 (Boston: Daughters of St. Paul 1980). In such circumstances:

> For doctors and their assistants it is not a question of deciding the life or death of an individual. It is simply a question of being a doctor, that is of posing the question and then deciding according to one's expertise and one's conscience regarding a respectful care of the living and the dying of the patient en-

> trusted to one. This responsibility does not always and in all cases involve recourse to every means [of treatment]. It might also require the renunciation of certain means to make way for a serene and Christian acceptance of death, which is inherent in life. It might also mean respect for the wishes of the patient who refuses the use of such means.

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 121 (Boston: Daughters of St. Paul 1995). Properly understood, forgoing treatment occurs with neither the patient nor the physician desiring that death occur. Neither intends to cause or hasten it. Instead, the inquiry focuses on whether the medical treatment in question is effective, overly burdensome, and requires heroic virtue to endure. If so, the patient may choose to forgo the treatment as an end in itself. *Id.* The fact that death may result is merely a foreseen but unintended side effect. *Id.*

Medical science can offer numerous examples in which the decision to forgo medical treatment does not involve an intent to kill or to die. For example, a feeding tube can become hopelessly burdensome. The tube can cause significant pain, it can result in serious infection, and it can fail to transmit nourishment effectively. Under such circumstances, the patient might well choose to forgo the feeding tube as disproportionately burdensome. The patient could make such a choice, however, while at the same time hoping that he or she could be effectively fed intravenously and praying that the underlying pathology would abate. The fact that intravenous feeding may turn out ultimately to be ineffective and that the patient ultimately may die as a result does not change the analysis.

The Second and Ninth Circuits, in rejecting any distinction between assisted suicide and forgoing medical treatment, seem to confuse purpose or intent with knowledge. Vacco App. at 30a-31a; Glucksberg App. at 78-82. As the Ninth Circuit held:

> [W]e see little, if any, difference for constitutional . . . purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the *known* effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. *To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.*

Glucksberg App. at 82 (emphasis supplied).

This Court previously has highlighted the distinction between purpose and knowledge. In *United States v. Bailey*,[20] for example, the Court recognized that "[f]ew areas of criminal law pose more difficulty than the proper definition of the *mens rea* required for any particular crime."[21] *Bailey* established a "hierarchy of culpable states of mind" and distinguished among "purpose, knowledge, recklessness, and negligence."[22] In doing so, it explained that "[p]erhaps the most significant and most esoteric, distinction drawn by this analysis is that between the mental states of 'purpose' and 'knowledge.'"[23] The distinction becomes particularly important:

> [i]n certain narrow classes of crimes [where] . . . heightened culpability has been thought to merit special attention. Thus, the statutory and common law of homicide often distinguishes, either in setting

[20] 444 U.S. 394 (1980).

[21] *Id.* at 408.

[22] *Id.* at 404.

[23] *Id.*

> the "degree" of the crime or in imposing punishment, between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life.[24]

As a definitional matter, this Court held that:

> [A] person who causes a particular result is said to act purposely if "he consciously desires that result, whatever the likelihood of that result happening from his conduct," while he is said to act knowingly if he is aware "that the result is practically certain to follow from his conduct, whatever his desire may be as to that result."[25]

This Court's recognition of the distinction between purpose, on the one hand, and a foreseen but unintended side effect, on the other, is perhaps most clearly set out in *Personnel Adm'r of Mass. v. Feeney*.[26] There, the Court relied on the distinction (sometimes referred to as the "principle of double effect") in addressing a claim that Massachusetts had discriminated impermissibly on the basis of gender by giving hiring preferences to military veterans, most of whom were men. *Feeney*, 442 U.S. at 259. The Court observed:

> The appellee's ultimate argument rests upon the presumption, common to the criminal and civil law, that a person intends the natural and foreseeable consequences of his voluntary actions. . . . [Culpable] purpose, however, implies more than intent as volition or intent as awareness of consequences. It implies that the decisionmaker, in this case a state legislature, selected or reaffirmed a particular course of action at least in part "because of," not merely "in spite of," its adverse effects . . . .

Id. at 278-79.

[24] *Id.* at 405.

[25] *Id.* at 404 (citation omitted).

[26] 442 U.S. 256 (1979).

Respondents may argue that, apart from any distinction between assisted suicide and forgoing medical treatment, many people actually forgo medical treatment with the intent of hastening death. That, unfortunately, may be so, but it does not lessen in any way the validity of the distinction for those who forgo treatment without an intent to kill. Nor does it disable the State from relying on the distinction in determining which conduct should be proscribed.

The fact that statutes in all fifty states distinguish between forgoing certain medical treatment and physician assisted suicide confirms both the reasonableness and the widespread nature of the distinction. Appendix B lists the numerous state living will statutes that expressly permit forgoing life support but at the same time reject physician assisted suicide. Appendix A lists the many state court decisions that adopt the same distinction. Appendix C lists the state statutes and judicial decisions that criminalize assisting a suicide but say nothing about forgoing medical treatment. All of this authority supports the proposition that a person's intent is central in determining the proper legal characterization of acts or omissions. As Justice Scalia wrote in *Cruzan*:

> Starving oneself to death is no different from putting a gun to one's own temple as far as the common law definition of suicide is concerned [because both involve] "the suicide's *conscious decision* to [put] an end to his own existence."

Cruzan, 497 U.S. at 296-97 (Scalia, J., concurring) (emphasis supplied and citations omitted).

Respondents also may argue that physicians at times cause death by employing measures deliberately chosen for the treatment of pain. Indeed, both the Second and Ninth Circuit explicitly mention such allegations in their opinions below. Vacco App. at 30a-31a; Glucksberg App. at 79. Once again, the physician's purpose, the result the physician intends to produce, provides a principled basis

on which to distinguish between assisted suicide and palliative care. As one medical text observes:

> Human and Christian prudence suggests the use for most patients of medicines which alleviate or suppress pain, even if this causes torpor or reduced lucidity. . . . When "proportionate means" so require, "it is permitted to use with moderation narcotics which alleviate suffering, but which also hasten death." In this case, "death is not intended or sought in any way, although there is a risk of it for a reasonable cause: what is intended is simply the alleviation of pain in an effective way, using for that purpose those painkillers available to medicine."

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶¶ 122-23 (Boston: Daughters of St. Paul 1995), *quoting* Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 548 (Boston: Daughters of St. Paul 1980). Further, the opinions below vastly underrate both medical science's capacity to treat pain effectively and its ability to avoid any unintended lethal side effects of palliative care. *See, e.g.*, Michael H. Levy, *Drug Therapy: Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1124-32 (1996) (noting that the appropriate use of pain medications, particularly in combination, "rarely results in respiratory depression or cardiovascular collapse").

In order for the New York and Washington State statutory schemes to survive equal protection scrutiny, they need only a rational basis. *Cleburne Living Ctr.*, 473 U.S. at 440. The fact that a statute may have other effects or be unwise as a matter of public policy will not suffice. *Id.* Only if such legislation is irrational will the Court invalidate it. *Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 462 (1988) ("Social and economic legislation . . . carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality."). Indeed, in discussing such rational basis scrutiny, this Court has stated that:

> the Fourteenth Amendment permits the States a wide scope of discretion in enacting laws which affect some groups of citizens differently than others. The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality. A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.

McGowan v. Maryland, 366 U.S. 420, 425-26 (1961). Given the intent-based distinction between assisted suicide and forgoing medical treatment, the New York and Washington State statutory schemes more than satisfy the constitutional requirement of rationality and non-arbitrariness.

CONCLUSION

The judgments of the courts of appeals should be reversed.

Respectfully submitted,

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APPENDICES

APPENDIX A

The state courts of last resort that have distinguished between forgoing life support and assisted suicide include:

Rasmussen v. Fleming, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987)

Thor v. Superior Court, 5 Cal. 4th 725, 742, 855 P.2d 375, 385, 21 Cal. Rptr. 2d 357, 367 (1993)

McConnell v. Beverly Enters., 209 Conn. 692, 710, 553 A.2d 596, 605 (1989)

In re Browning, 568 So. 2d 4, 14 (Fla. 1990)

State v. McAfee, 259 Ga. 579, 580, 385 S.E.2d 651, 652 (1989)

In re Estate of Longeway, 133 Ill. 2d 33, 41, 549 N.E.2d 292, 296 (1989)

In re Lawrance, 579 N.E.2d 32, 40 n.4 (Ind. 1991)

DeGrella ex rel. Parrent v. Elston, 858 S.W.2d 698, 707 (Ky. 1993)

In re P.V.W., 424 So. 2d 1015, 1022 (La. 1982)

In re Gardner, 534 A.2d 947, 955-56 (Me. 1987)

In re Doe, 411 Mass. 512, 522, 583 N.E.2d 1263, 1270, *cert. denied*, 503 U.S. 950 (1992)

Brophy v. New England Sinai Hosp., 398 Mass. 417, 439, 497 N.E.2d 626, 638 (1986).

Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 744 n.11, 370 N.E.2d 417, 426 n.11 (1961)

People v. Kevorkian, 447 Mich. 436, 472-73, 527 N.W.2d 714, 728-29 (1994), *cert. denied*, 115 S. Ct. 1795 (1995)

McKay v. Bergstedt, 106 Nev. 808, 823, 801 P.2d 617, 627 (1990)

In re Farrell, 108 N.J. 335, 350, 529 A.2d 404, 411 (1987)

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985)

In re Quinlan, 70 N.J. 10, 51-52 & n.9, 355 A.2d 647, 669-70 & n.9, *cert. denied*, 429 U.S. 922 (1976)
Fosmire v. Nicoleau, 75 N.Y.2d 218, 227 n.2, 551 N.E.2d 77, 82 n.2, 551 N.Y.S.2d 876, 881 n.2 (1990)
In re Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 358 (1981)
In re Fiori, 673 A.2d 905, 910 (Pa. 1996)
In re Grant, 109 Wash. 2d 545, 563-64, 747 P.2d 445, 454-55 (1987), *modified on other grounds*, 757 P.2d 534 (Wash. 1988)
In re L.W., 167 Wis. 2d 53, 83, 482 N.W.2d 60, 71 (1992)

A number of state lower courts have also distinguished between forgoing life support and assisted suicide, including:

Donaldson v. Lundgren, 2 Cal. App. 4th 1614, 1621, 4 Cal. Rptr. 2d 59, 62 (1992)
People v. Adams, 216 Cal. App. 3d 1431, 1440, 265 Cal. Rtpr. 568, 573-74 (1990)
Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1144-45, 225 Cal. Rptr. 297, 306 (1986)
Bartling v. Superior Court, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 225 (1984)
Barber v. Superior Court, 147 Cal. App. 3d 1006, 1012, 195 Cal. Rptr. 484, 487 (1983)
Foody v. Manchester Mem. Hosp., 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (Super. Ct. 1984)
In re Severns, 425 A.2d 156, 158 (Del. Ch. 1980)
Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980)
In re Rosebush, 195 Mich. App. 675, 681 n.2, 491 N.W.2d 633, 636 n.2 (1992)
Von Holden v. Chapman, 87 A.D.2d 66, 70, 450 N.Y.S.2d 623, 627 (App. Div. 1982)

In re Eichner, 102 Misc. 2d 184, 205, 423 N.Y.S.2d 580, 594 (Sup. Ct. 1979), *aff'd as modified sub nom. Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S. 2d 517 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 52 N.Y.S.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)
Leach v. Akron Gen. Med. Ctr., 68 Ohio Misc. 1, 10, 426 N.E.2d 809, 815 (Ct. C.P. 1980)
In re Fiori, 438 Pa. Super. 610, 619, 652 A.2d 1350, 1354 (1995) (en banc), *aff'd*, 673 A.2d 905 (Pa. 1996)

APPENDIX B

The state living will statutes that distinguish between forgoing life support and assisted suicide include the following:

Ala. Code § 22-8A-10 (1995)
Alaska Stat. § 18.12.080(f) (1995)
Ariz. Rev. Stat. Ann. § 36-3210 (1995)
Ark. Code Ann. § 20-17-210(g) (Michie 1995)
Cal. Health & Safety Code § 7191.5(g) (West 1995)
Colo. Rev. Stat. Ann. § 15-18-112(1) (West 1995)
Conn. Gen. Stat. Ann. § 19a-575 (West 1995)
Del. Code Ann. tit. 16, § 2507 (1995)
D.C. Code Ann. § 6-2430 (1995)
D.C. Code Ann. § 21-2212 (1995) (durable power of attorney for health care)
Fla. Stat. Ann. § 765.309(1) (West 1995)
Ga. Code Ann. § 31-32-9 (1995)
Ga. Code Ann. § 31-36-2 (1995) (durable power of attorney for health care)
Haw. Rev. Stat. § 327D-13 (1995)
Idaho Code § 39-161(1) (1995) (do not resuscitate orders)
Ill. Comp. Stat. ch. 755, para. 35/9(f) (Smith-Hurd 1995)
Ill. Comp. Stat. ch. 755, para. 40/50 (Smith-Hurd 1995) (durable power of attorney for health care)
Ind. Code Ann. § 16-36-1-13 (West 1995) (durable power of attorney for health care)
Ind. Code Ann. § 16-36-4-19 (West 1995)
Iowa Code Ann. § 144A.11.6 (West 1995)
Iowa Code Ann. § 144B.12.2 (West 1995) (durable power of attorney for health care)
Kan. Stat. Ann. § 65-28,109 (1995)
Ky. Rev. Stat. Ann. § 311.637 (Baldwin 1995)
La. Rev. Stat. Ann. § 1299.58.10 (West 1995)
Me. Rev. Stat. Ann. tit. 18-A, § 5-813 (West 1995)
Md. Code Ann., Health-Gen. § 5-611 (1995)
Mass. Gen. Laws Ann. ch. 201D, § 12 (West 1995) (durable power of attorney for health care)

Mich. Comp. Laws Ann. § 700.496(20) (West 1995) (durable power of attorney for health care)
Minn. Stat. Ann. § 145B.14 (West 1995)
Miss. Code Ann. § 41-41-117(2) (1993)
Mo. Ann. Stat. § 459.055(5) (Vernon 1995)
Mont. Code Ann. § 50-9-205(7) (1995)
Neb. Rev. Stat. § 20-412(7) (1995)
Nev. Rev. Stat. § 449.670(2) (1993)
N.H. Rev. Stat. Ann. § 137-H:10(II) (1995)
N.J. Stat. Ann. § 26:2H-54(e) (West 1995)
N.M. Stat. Ann. § 24-7-8 (Michie 1996)
N.Y. Pub. Health Law § 2989(3) (McKinney 1995) (durable power of attorney for health care)
N.C. Gen. Stat. § 90-320(b) (1995)
N.D. Cent. Code § 23-06.4-01 (1995)
N.D. Cent. Code § 23-06.5-01 (1995) (durable power of attorney for health care)
Ohio Rev. Code Ann. § 2133.12(d) (Baldwin 1996)
Okla. Stat. Ann. tit. 63, § 3101.12(g) (West 1995)
Or. Rev. Stat. § 127.570 (1995)
20 Pa. Cons. Stat. Ann. § 5402(b) (1995)
R.I. Gen. Laws § 23-4.10-9(f) (1995) (durable power of attorney for health care)
R.I. Gen. Laws § 23-4.11-10(f) (1995)
S.C. Code Ann. § 44-77-130 (Law. Co-op. 1993)
S.D. Codified Laws Ann. § 34-12D-20 (1996)
Tenn. Code Ann. § 32-11-110 (1995)
Tex. Health & Safety Code Ann. § 672.020 (West 1995)
Utah Code Ann. § 75-2-1118 (1995)
Vt. Stat. Ann. tit. 18, § 5260 (1995)
Va. Code Ann. § 54.1-2990 (Michie 1995)
Wash. Rev. Code Ann. § 70.122.100 (West 1995)
W. Va. Code § 16-30-10 (1995)
Wis. Stat. Ann. § 154.11(6) (West 1995)
Wyo. Stat. § 3-5-211 (1995) (durable power of attorney for health care)
Wyo. Stat. § 35-22-109 (1995)

APPENDIX C

This appendix lists the forty-five states that criminalize assisted suicide, either by statute or judicial decision.

The following thirty-seven states and territories have statutes that explicitly impose criminal penalties for assisting a suicide:

Alaska Stat. § 11.41.120(a)(2) (1995)
Ariz. Rev. Stat. Ann. § 13-1103(A)(3) (1995)
Ark. Code Ann. § 5-10-104(a)(2) (Michie 1995)
Cal. Penal Code § 401 (West 1995)
Colo. Rev. Stat. § 18-3-104(1)(b) (West 1995)
Conn. Gen. Stat. Ann. § 53a-56(a)(2) (West 1995)
Del. Code Ann. tit. 11, § 645 (1995)
Fla. Stat. Ann. § 782.08 (West 1995)
Ga. Code Ann. § 16-5-5(b) (1995)
Haw. Rev. Stat. § 707-702 (1995)
Ill. Comp. Stat. ch. 720, para. 5/12-31 (Smith-Hurd 1995)
Ind. Code Ann. § 35-42-1-2.5(b) (West 1995)
Iowa Code Ann. §§ 707A.2, 707A.3 (West 1996)
Kan. Stat. Ann. § 21-3406 (1995)
Ky. Rev. Stat. Ann. § 216.302 (Baldwin 1995)
La. Rev. Stat. Ann. § 14:32.12 (West 1995)
Me. Rev. Stat. Ann. tit. 17-A, § 204 (West 1995)
Minn. Stat. Ann. § 609.215 (West 1995)
Miss. Code Ann. § 97-3-49 (1993)
Mo. Ann. Stat. § 565.023(1)(2) (Vernon 1995)
Mont. Code Ann. § 45-5-105 (1993)
Neb. Rev. Stat. § 28-307 (1995)
N.H. Rev. Stat. Ann. § 630:4 (1995)
N.J. Stat. Ann. § 2C:11-6 (West 1995)
N.M. Stat. Ann. § 30-2-4 (Michie 1995)
N.Y. Penal Law § 120.30 (McKinney 1995)
N.Y. Penal Law § 125.15 (McKinney 1995)
N.D. Cent. Code § 12.1-16-04 (1995)
Okla. Stat. Ann. tit. 21, § 813 (West 1995)
Or. Rev. Stat. § 163.125(b) (1995)
18 Pa. Cons. Stat. Ann. § 2505 (1995)

P.R. Laws Ann. tit. 33, § 4009 (1990)
S.D. Codified Laws Ann. § 22-16-37 (1996)
Tenn. Code Ann. § 39-13-216 (1995)
Tex. Penal Code Ann. § 22.08 (West 1995)
V.I. Code Ann. tit. 14, § 2141 (1994)
Wash. Rev. Code Ann. § 9A.36.060 (West 1995)
Wis. Stat. Ann. § 940.12 (West 1995)

The following two states have negligent homicide statutes broad enough to penalize assisting a suicide: Ala. Code § 13A-6-4 (1995); and Wyo. Stat. § 6-2-107 (1995).

The following six states have case law authorizing the imposition of criminal penalties for assisting a suicide: *McMahan v. State*, 168 Ala. 70, 73, 53 So. 89, 91 (1910); *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (1877); *Commonwealth v. Bowen*, 13 Mass. 356, 358 (1816); *People v. Kevorkian*, 447 Mich. 436, 493-97, 527 N.W. 2d 714, 738-39 (1994), *cert. denied*, 115 S. Ct. 1795 (1995); *State v. Willis*, 255 N.C. 473, 477, 121 S.E.2d 854, 856-57 (1961); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); and *State v. Jones*, 86 S.C. 17, 22, 47, 67 S.E. 160, 162, 165 (1910).

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No. 95-1858
No. 96-110

In The
Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D.,
and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
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A-4 *Compassion in Dying* Respondents' Letter of Consent to File *Amicus* Brief

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Uniform Healthcare Decisions Act, 9 U.L.A. 220 (1996) 18-19

Uniform Rights of the Terminally Ill Act, 9B U.L.A. 609 (1987) 18

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Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183 (Fall 1990) (citing Spencer, U.S. Bureau of the Census, *Projections of the Populations of the United States by Age, Sex, and Race: 1983-2080, in Current Population Reports*, Series P-25 No. 952 (Mar. 1984)) 11

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INTEREST OF THE *AMICUS*

The American College of Legal Medicine ("ACLM") respectfully submits this brief as an *amicus curiae* pursuant to Rule 37 of the Rules of the Supreme Court of the United States, and submits it in each of these cases. ACLM's position in this brief directly supports neither the petitioners nor the respondents in either case, instead advocating a neutral position that ACLM believes would best achieve the optimal outcome in these cases. ACLM has received the consent of all parties to submit this brief pursuant to the applicable rules of this Court. *See* Appendix A.

Founded in 1960, ACLM is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of about 1300 professionals, including physicians and scientists in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM is officially recognized by the American Medical Association ("AMA") as the society that represents legal and medical specialists, and ACLM holds a seat in the AMA House of Delegates.

ACLM's interest in these cases derives from the current prominence of the issue commonly known as physician-assisted suicide, coupled with a fear that advocates of each of the polar positions on this divisive issue fail to adequately appreciate the merits of the other. ACLM's interest is additionally driven by the fact that the aging of the "baby-boomer" generation will force an increasing number of individuals into end-of-life treatment decisions, particularly as continued advances in medical science enable physicians to prolong life notwithstanding the quality of that life. ACLM believes that, ideally, law and policy ought to amalgamate the most significant concerns on each side of this issue, in a manner that responsibly and pragmatically accounts for society's traditional abhorrence of suicide, without sacrificing the interests of those who endure the unfathomable pain and suffering often associated with the end-stages of terminal illnesses. ACLM asserts that there is a middle-ground that will both protect the state's and society's interest in promoting and preserving meaningful life, and serve the interests of those who are some of the most desperate individuals in our society. Importantly, ACLM respectfully submits that this Court can reach such a balance within a constitutional framework premised upon its past decisions.

SUMMARY OF THE ARGUMENT

ACLM believes that a mentally-competent adult in the end-stages of a terminal illness owns the right to control end-of-life medical treatment decisions, such as refusing and terminating unwanted medical treatment -- a right recognized and protected by this Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). ACLM urges this Court to interpret end-of-life treatment decisions for such patients to include the right to obtain treatment intended to end life.

ACLM recognizes, however, that the state and society have a legitimate and compelling interest in ensuring that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. To protect against such abuse, ACLM believes it essential to regulate, through protocols, the administration of treatment intended to end life. Paramount, too, is strict enforcement of these protocols, through means to be established by the states in collaboration with the healthcare community.

ACLM's position is premised necessarily on the efficacy of these protocols. In this regard, ACLM presents to this Court for its consideration a compilation of the many varieties of healthcare-related regulations and protocols already in place. The benefits of consideration of these protocols are three-fold: First, it demonstrates that comprehensive regulations on end-of-life medical treatment imposed by

federal and state statutes, as well as by the healthcare community itself, not only exist, but also have effectively allowed for the responsible administration of end-of-life treatment and care. Second, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. Third, to the extent that existing regulations would not apply to the treatment at issue here, the regulations nevertheless provide a framework upon which applicable restrictions can and should be crafted.

Finally, ACLM acknowledges the context in which the instant issue arises, *i.e.*, a challenge to the constitutionality of statutes criminalizing physician treatment intended to end life. ACLM demonstrates herein that the right it asks this Court to recognize in no way constitutes a radical expansion of the rights already secured by our Constitution, but rather is consistent with Fourteenth Amendment rights that already have been recognized by this Court.

ARGUMENT

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leave my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know that if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.
>
> Seneca
> Roman Orator
> *circa* 3 B.C. - A.D. 65

I. The Right of Mentally-Competent Adults in the End-Stages of a Terminal Illness To Obtain Medical Treatment Intended To End Life Is Essential to Preserve Human Dignity in Dying.

The issue in these cases -- whether a mentally-competent adult in the end-stages of a terminal illness has a right to medical treatment intended to end life -- creates virulent debate and a division in public opinion equaled by few, if any, other issues of the day; the debate and division, however, are understandable. Proponents on one side argue that what is at stake is perhaps the most fundamental right known to humankind -- the right to control one's body and life; advocates on the other side equate the acts at issue here to suicide by the patient, and to killing by the physician. For this reason, ACLM urges this Court to focus not only upon the constitutional analysis, as of course it must, but also upon the consequences and policy implications of a decision premised upon that analysis.

A. The Term "Physician-Assisted Suicide" Colors The Issue.

Semantics, of course, do not resolve the instant issue. Yet, the term "physician-assisted suicide" is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality. The appropriateness of the term is doubtful in several respects. First, neither the New York nor the Washington statute at issue in these cases contain the phrase "physician-assisted suicide." *See* N.Y. Penal Law §125.15(3) (McKinney 1987); Wash.Rev.Code §9A.36.060 (1980). Second, the word "suicide" itself is defined not only as the "taking of one's own life" but also as the "destruction or ruin of one's own interests." *Webster's Third New International Dictionary*, 2286 (1981). As exemplified in the discussion below, it seems inappropriate to characterize requests for treatment that ends life, made by suffering, terminally-ill patients, as any form of destruction or

ruination of their interests. Assuming a patient's mental competence, and recognizing this Court's long-held commitment to the principles of personal autonomy and free will (*see, e.g., Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847, 851 (1992) (both quoted *infra*)), prescribing medication intended to end life in the subject context *serves* -- not destroys or ruins -- a patient's interests. For these reasons, ACLM questions whether the subject statutes even apply to the situation in which a physician cares for a mentally-competent adult in the end-stages of a terminal illness with medical treatment intended to end life. Notwithstanding that fact, ACLM rejects the term "physician-assisted suicide," and instead refers herein to the practice in question as "treatment intended to end life."

B. Individual Patient's Conditions Demonstrate That Treatment Intended To End Life Can Be Essential To Dying With Dignity.

In forming policy on this issue, it is critically important to consider the horrific situation in which, unfortunately, innumerable patients find themselves. These patients' individual stories enlighten us to the experience of dying a slow, painful and agonizing death. Consider the following:

> Jane Doe was a mentally-competent adult in the end-stage of cancer. She endured a cancerous tumor that had wrapped around her right carotid artery, collapsing her esophagus and invading her voice box. The tumor restricted her ability to swallow and prevented her from eating anything but very thin liquids in extremely small amounts. Eventually, she was placed on a feeding tube, which caused serious additional medical problems.

Quill v. Vacco, 80 F.3d 716, 720 (2d Cir. 1996); *see also Cruzan*, 497 U.S. 261, 289 (O'Connor, J., concurring)

("[b]ecause of the discomfort such a [feeding] tube causes, [m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube" (citation omitted)).

> William A. Barth was a mentally-competent adult in the end-stage of AIDS, who had endured years of radiation and chemotherapy treatment for cancer. As a result of AIDS, he contracted (a) cytomegalovirus in his stomach and colon which caused severe diarrhea, fevers and wasting; (b) a type of parasitic infection which independently caused severe diarrhea, extreme abdominal pain, nausea and additional significant wasting; (c) another type of parasitic infection for which there was no treatment; and (d) pneumonia, for which he regularly took infusion therapy treatment that was so toxic he vomited with each infusion.

Quill, 80 F.3d 716, 720.

These are the histories of just two of the plaintiffs in these cases, each of whom filed their lawsuit asserting a right to care and treatment to end life, and each of whom has died from disease during the pendency of these cases. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 795 (9th Cir. 1996); *Quill*, 80 F.3d at 722. Repeating these stories is essential to recognizing an inescapable conclusion: Individuals who seek care and treatment intended to end life include human beings who suffer a torturous existence. Notwithstanding the impact of descriptive language that ingrains these patients' suffering, the extent of their misery is, by its nature, beyond the comprehension of anyone not in their position. While these stories surely evoke feelings of compassion, no one should pretend to know definitively whether he or she would desire life-ending care and treatment in a like situation. Moreover, from these patients' situations, we also understand that they suffered excruciating pain beyond

the bounds of non-lethal doses of pain medication, and further, that they endured the indignities that come with failing bodies. For each, death was imminent and certain, but for each, every moment of that existence was torturous.

It is also significant to realize that these histories are not a few isolated situations, which, for better or worse, are mooted by these patients' respective deaths. The average age of the population of the United States is rising, while at the same time, advances in medical science enable physicians to maintain life long beyond the stage at which fatal disease causes physical incapacitation and unendurable pain. As Professor George P. Smith II noted,

> Life is not an amaranth, the imaginary flower that never fades. For all too many, the "benefits" of modern medicine and treatment extend the fading process with tragic withering, discoloration and odor.

Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?* 22 U.C. Davis L.Rev. 275, 281 (1989) ("Smith"). Without life-ending treatment, a mentally-competent patient in the end-stages of a terminal illness is left with an option of a conscious existence that is excruciatingly painful and devoid of dignity, or alternatively, medications that diminish or end consciousness, thereby rendering continued life meaningless. ACLM respectfully submits that, in a free, humane and civil society, this is no option at all. For patients in this condition, the right to care and treatment intended to end life is necessary to avoid pointless suffering and maintain personal dignity in the final phase of their life.

C. Protocols Will Offset The Potential For Abuse

As the Ninth Circuit aptly noted in its decision on appeal, "[r]ecognition of any right creates the possibility of abuse."

Compassion in Dying, 79 F.2d at 831. Indeed, the state has a legitimate and compelling interest to ensure that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. But, as this Court recognized in *Cruzan*, where such potential for abuse exists, the state simply must "guard against potential abuses." 497 U.S. 261, 281.

ACLM agrees. To avoid abuses, it is incumbent upon government in collaboration with the healthcare community to establish regulations on the administration of treatment intended to end life. As shown in greater detail *infra*, there are abundant mechanisms in existence today which serve to regulate healthcare and treatment -- some in the form of federal and state legislation, and many in the form of protocols established by the healthcare community itself.

Critical, too, is the enforcement of these statutes, regulations and protocols. For example, "[i]f an individual [physician] abuses the privilege of exercising proper medical judgment" in administering treatment intended to end life, "the usual remedies, judicial and intra-professional, are available." *Roe v. Wade*, 410 U.S. 113, 167 (1973).

Which regulatory mechanisms, protocols and associated penalties will most successfully avoid abuses in the context of the right at issue here is best-determined through the collaborative initiatives of the state and the healthcare community. Obviously, penalties for any violation of law, regulation or protocol should be commensurate with the seriousness of the offense. And although this Court's decision in *Cruzan*, too, recognized a right which seemed wrought with the potential for abuse, this Court expressed its justified confidence in the ability of states and the healthcare community to craft appropriate regulations:

> Today we decide only that one State's practice does not violate the Constitution; the more challenging

> task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States....

Cruzan, 497 U.S. 261, 292 (citation omitted). As shown *infra*, states and the healthcare community have responded impressively with respect to regulating the withdrawal of life-support systems. Contrary to the early critics of *Cruzan*, since this Court rendered its decision in that case, there has *not* been a public outcry of abuse, nor do we hear of utilizing *Cruzan* to endanger the elderly, infirm, disabled and indigent. This oft-heard slippery slope argument is unfounded due to the substantiated fact that the states and the healthcare community possess the skill and know-how to manage and administer end-of-life treatment decisions. Simply stated, the slippery slope proved to be nothing but an imaginary hill. Moreover, to doubt now the collective wisdom of the states and healthcare community would be to reject the premise of this Court's holdings in *Roe v. Wade*, *Cruzan* and *Casey*.

II. End-Of-Life Decisions Should Follow Protocols Intended To Respect The Dignity Of Patients And The Sanctity Of The Patient-Physician Relationship.

As a result of the "growing medicalization of death" (Smith, *supra* at 359; *see also* Quill, *et al.*, *Care of the Hopelessly Ill - Proposed Clinical Criteria*, 327 N.Eng.J.Med. 1380 (1992)), the responsibility of the healthcare community in this era of medical technology is profound and daunting. The most sacred patient-physician relationship, once established and seen as a collaborative effort, should not be forced to end at a time when an individual's values and integrity are at their most critical juncture. The physician's ability to care for a patient is at no time more meaningful than when the doctor affirms the dignity of the patient through assistance in end-of-life treatment decisions.

ACLM, however, advocates that a physician assist a patient in end-of-life treatment decisions only through the use of strict protocols, intended to evaluate a patient's medical, physical, emotional, psychological and social state of being. Prior to the administration of any treatment intended to end life, a physician should be required to thoroughly discuss all medical options available to the patient, if any, including palliative care. ACLM, too, is cognizant of, and concerned over, the potential abuse of the elderly, infirm and indigent arising out of end-of-life treatment decisions. To date, however, existing protocols regarding the termination or withdrawal of life-sustaining treatment have vastly decreased the possibility of such abuse.

For example, federal and state advance directive statutes are prevalent throughout the country, and they assist individuals in documenting and implementing their end-of-life decisions.[1] As of March, 1996, for instance, almost every state authorizes either living wills or the appointment of a healthcare agent, or both.[2] *See* Choice In Dying, *Diagram of State Statutes Governing Living Wills and Appointment of Healthcare Agents* (1996) (Appendix B). In order to implement these advance directives, healthcare facilities

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1 An Advance Directive is an "explicit statement by a decisionally-capable adult, either written or communicated orally, that states preference for medical care in the future if the person should no longer be able to consider the medical options and communicate a preference. Dubler and Marcus, *Mediating Bioethical Disputes* 77 (1994).

2 A living will relating to the use of life sustaining treatment specifies under what medical conditions a physician is instructed by a patient to withhold or withdraw treatment. Such conditions usually include an incurable and irreversible condition that without the administration of life-sustaining treatment, would cause the death of a patient.

A health care agent also referred to as an attorney-in-fact, judicially appointed guardian or a power of attorney for healthcare, is an individual appointed by the patient to make decisions on the patient's behalf regarding the withholding or withdrawal of life-sustaining treatment whenever the patient is no longer capable of making his or her own treatment decisions.

employ protocols and ethics committees[3] that enable medical and nursing staff to comply with patients' pre-determined medical treatment decisions.

The existence of such advance directives and protocols to implement them is more important than ever before.[4] It is estimated that, by 2050, over 20% of our population will have reached the age of 65 or older (compared to 4% in the early 1900's). Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183, 189 (Fall 1990) (citing Spencer, U.S. Bureau of the Census, *Projections of the Populations of the United States by Age, Sex, and Race: 1983-2080, in Current Population Reports*, Series P-25 No. 952 (Mar. 1984)). Moreover, the number of individuals over 85 living in nursing homes will increase from 22% in 1985 to triple that number in 2010 (Cohen, *supra* at 189, citing *Aging Americana: Trends and Projections*, 1987-1988 U.S. Senate Special Comm. on Aging, p. 118), many of whom may be suffering from Alzheimer's Disease. *Id.*, citing Evans, *et al*, *Clinically Diagnosed Alzheimer's Disease: An Epidemiological Study in Community Population of Older Persons*, 262 JAMA, 2551-2556 (1989). "Baby-boomers" who are currently debating the issue of end-of-life treatment decisions will be faced with this very issue within the next twenty to fifty years. Treatment decisions to end life will no longer be legal and medical issues as much as they will be societal issues -- issues that must be confronted, and these cases provide for this opportunity.

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3 An ethics committee is a "[c]onsultative committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients and families regarding difficult treatment decisions", including end-of-life decisions. Dubler & Marcus *supra* at 79; *see also* Hastings Center, *Guidelines on Termination of Life Sustaining Treatment and the Care of the Dying*, *supra*, 100-105 (1987).

4 A recent study confirmed that patients suffering from a terminal illness *frequently* contemplate end-of-life medical treatment issues. Emanuel, *et al.*, *Euthanasia and Physician Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 Lancet 1805-10 (1996).

A. The Patient Self-Determination Act Proves That Advance Directives Are An Effective Means To Express Patients' Treatment Decisions.

In response to *Cruzan*, the legal community in collaboration with healthcare experts created and enacted the Patient Self-Determination Act ("PSDA") (42 U.S.C. §1395 cc(f) (West 1992 & Supp. 1996)). Since its enactment, the PSDA has served as the procedural linchpin upon which healthcare institutions, physicians and patients currently rely with respect to end-of-life treatment options and decisions. The PSDA requires *all* hospitals, skilled nursing facilities, home health agencies, hospital programs and health maintenance organizations (HMOs), that receive Medicare or Medicaid funding, to educate patients about advance directives. Specifically, healthcare facilities must provide patients, upon admission, with information regarding their state-law rights regarding end-of-life decisions, including the right to refuse or accept any form of medical treatment, and the right to exercise an advance directive (if one has not already been prepared). Whether the patient has executed an advance directive must be documented in the patient's medical chart to ensure compliance with the patient's direction. Patients are not required to execute advance directives, and their medical care is in no way conditioned upon their execution of one. The PSDA also recognizes that, for moral, ethical or religious reasons, medical institutions or medical staff may not be willing to comply with any particular form of treatment set forth in an advance directive. The PSDA, therefore, requires that patients be notified of these beliefs.

Furthermore, the PSDA requires that institutional staff, as well as the community at large, be provided with information regarding advance directives. This aspect of the PSDA is critical if patients, families, healthcare institutions and communities are to understand the impact advance directives can have on individuals, and on society as a whole.

ACLM believes that the PSDA should be applicable to all end-of-life treatment decisions, including treatment intended to end life.

B. Healthcare Institutions Use Protocols That Promote Compliance With Patients' Treatment Decisions, And Committees That Assist In The Resolution Of Bioethical Disputes.

For decades, healthcare institutions have taken a leading role in recognizing and lending support to patient decision-making. For instance, hospitals have established policies that assist medical staff in determining a patient's decision-making capacity, including a patient's ability to make end-of-life treatment choices. Similarly, the American Hospital Association's *Policy and Statement on Patient's Choice of Treatment Options* (1985) (*see* Appendix C) provides that "[h]ealth care decision making should be based on a collaborative relationship between the patient and the physician" and that "institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficient voluntary and informed decision." This policy also provides safeguards whereby patients can make decisions regarding the withholding and withdrawal of medical treatment.

Furthermore, the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"),[5] and by reference, the federal Medicare program, has set standards to assist healthcare facilities in creating and implementing policies and procedures with respect to obtaining a patient's informed

5 JCAHO is a private, voluntary accrediting organization, the principle roles of which include establishing standards for the operation of healthcare facilities, recognizing compliance with these standards through issuance of certificates of accreditation, and conducting surveys and accreditation programs that encourage and assist such facilities in promoting efficient, high-quality patient care.

consent to treatment. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RI 1.2.1 (1996). Pursuant to these standards, the ability of a patient to provide informed consent is conditioned upon the following factors: a patient must (1) have the capacity to make reasonable judgments; (2) have a clear understanding of the nature of his or her disease and prognosis, as well as an understanding of the risks and benefits associated with proposed treatment alternatives; and, (3) make decisions voluntarily and without any degree of coercion. Appelbaum and Gisso, *Assessing Patients' Capacity to Consent to Treatment*, 319 N.Eng.J.Med. 1635-1638 (1988).

Particularly relevant to the instant issue is a physician's ability to determine a patient's capacity to give informed consent where that patient suffers excruciating pain, dementia or depression. In order to gauge a patient's true desires on treatment, healthcare facilities employ the use of specialists, including pain-management specialists, gerontologists, psychiatrists and oncologists. Gordon and Linger, *Decisions and Care at the End of Life*, 346 Lancet 163-66 (1995).

Physicians who treat terminally-ill patients also consult with specialists knowledgeable in the use of palliative care, also known as "comfort care." "Palliative care" refers to medical, surgical and other interventions designed to alleviate "suffering, discomfort and dysfunction, whether physical or not, but not to cure". Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 141 (1987); *see also*, *Id.*, 73-75 ("Since patients know most fully the extent of their suffering and their need for relief, their wishes about palliative care and pain relief should guide professionals. Whenever possible, the patient, together with the responsible healthcare professional, should determine the degree and type of palliative and pain relief...."). Palliative care is utilized most often in hospice programs. The goal of this type of care is to relieve the patient's symptoms, and ease the process of dying by providing care and support

that enhance the quality and meaning of the patients' remaining life...." Miller et al., *Regulating Physician-Assisted Death,* 331 N.Eng.J.Med. 119 (1994).

Although some express concern over the ability of infirm and elderly patients to fully-comprehend treatment options and the impact of their treatment decisions, a comprehensive study has shown that such patients, in fact, do understand healthcare information, and that they are capable of making decisions regarding advance directives, through the use of simplified story books and discussion paralleling the patient's level of comprehension. Drynski, et al, *How Informed Can Consent Be? New Light on Comprehension Among Elderly People Making Decisions About Enteral Tube Feeding,* 34 The Gerontologist 36-43 (1994).

Furthermore, several states, including California, require skilled nursing facility patients to execute advance directives in the presence of patient advocates or ombudspersons (designated by the state), who specialize in treating the aged and infirm. *See, e.g.,* Cal. Health & Safety Code §7188 (West Supp. 1996). *See also* Ore.Rev.Stat. ch. 127.515(4)(e) (Supp. Part 2, 1994). This policy serves as yet another safeguard to the threat of abuse or coercion.

In fact, even prior to *Cruzan* and the PSDA, hospitals employed policies and procedures governing the acquisition of informed consent from the aged and infirm, and governing the withdrawal of life-sustaining treatment. Likewise, JCAHO, since January, 1988, has established hospital standards regarding the withholding and withdrawal of resuscitative services and life-sustaining treatment.

As these issues became more complex, hospitals began to address the moral, ethical and religious concerns relating to a patient's decision either to withdraw or forego treatment. Again, the healthcare community addressed this new-found problem effectively. Ethics committees were developed to

assist medical staff and patients in resolving these moral, ethical and religious conflicts arising out of a patient's treatment decisions. *See, e.g.,* Osborne, *Physician Decisions Regarding Life Support in the Intensive Care Unit; Ethics in Cardiopulmonary Medicine*, 101 Chest 135-145 (1992). Ethics committees became widely utilized after JCAHO published standards for hospitals regarding the recognition of bioethical disputes and establishment of policies and procedures to resolve these conflicts. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RI 1.2.3 at 76 (1996).

Depending on the milieu of an institution, ethics committees serve a variety of functions, including, (a) reviewing a patient's case to confirm that individual's diagnosis and prognosis; (b) providing a forum for discussing broader social and ethical concerns raised by a particular case; (c) educating professional staff how to identify, frame and resolve ethical problems; (d) formulating policy and guidelines regarding such decisions; and (e) reviewing decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment*, 160 (1983).

Cutting-edge innovative programs have also assisted hospitals and bioethics committees in mediating bioethical disputes and training hospital staff to facilitate resolution of disagreements among patients, family and medical staff. For example, the Center for Medical Ethics and Mediation, located in San Diego, California, currently teaches healthcare professionals and staff in hospitals and managed care facilities the theory and skills utilized in mediation of bioethical and health law disputes arising between medical staff and patients. The Center for Medical Ethics and Mediation, *Kaiser Permanente Re-engineers for Conflict-Positive Customer Relations*, 4 Pontis 1 (Spring 1996). Similarly, the Program

for Health Care Negotiation and Conflict Resolution at the Boston University School of Public Health collaborated with Montefiori Medical Center in New York to create a prototype of alternative dispute resolution techniques, particularly mediation, that could be used to resolve bioethical disputes in the hospital setting. Dubler & Marcus, *Mediating Bioethical Disputes*, 1994.

In response to the recognized need to educate physicians and healthcare practitioners regarding palliative and life-ending medical treatment,[6] palliative-care committees serve as an example of overseeing treatment decisions intended to end life. These committees, composed of lay members and professionals, "would be responsible for educating clinicians and the public about methods of comfort care (including pain management), ethical standards of informed refusal and discontinuation of life-sustaining treatment and the option of physician assisted death." Miller, *et al., Regulating Physician Assisted Death*, 331 N.Eng.J.Med. 119, 121 (1994).

C. The *Uniform Rights of the Terminally Ill Act* And The *Uniform Health Care Decisions Act* Effectively Regulate Treatment Decision-Making.

As stated, *supra*, the 1970's and 1980's saw a flurry of activity as states attempted to created advance directive statutes that recognized the need of their citizens to personally control their healthcare decision-making.

The increasing interest in advance directives served as a catalyst for the National Conference of Commissioners on Uniform State Laws ("Commissioners") to draft and approve

6 According to a 1992-93 survey conducted by the American Medical Association, of the nation's 126 medical school, only five have a required course on the care of dying patients. Gordon, *Perspective on Assisted Suicide: Doctors are Remiss at the Death Bed;* L.A. Times, Oct. 10, 1996 at B9.

the 1985 Uniform Rights of Terminally Ill Act ("Act") in 1985. 9B U.L.A. 609 (1987). Although the Act drew upon existing legislation, the Commissioners drafted language that was "simple, effective, and acceptable to those individuals desiring to execute a declaration and to physicians and health care facilities whose conduct [would] be affected. "The Act was crafted to avoid statutory inconsistencies that characterized earlier statues and provided that advance directives executed in one state would be reciprocally recognized in other states. *Id.* Various states have adopted some form of living will or advance directive based upon the model Act.

By 1993, as a result of *Cruzan*, the Commissioners created the Uniform Health Care Decisions Act, ("Health Care Decision Act"), which effectively superseded the Act. 9 U.L.A. 220 (1996). The intention of the drafters of the Health Care Decisions Act was to "pave a health care decisionmaking superhighway." C. Sabatino, *Symposium: Trends in Health Care Decisionmaking, Etc.*, 53 Md.L.Rev. 1238-1239 (1994). The Commissioners deleted such "preconditions such as certification of diagnosis of a terminal condition or permanent unconsciousness, the need for life-sustaining procedures, and special needs for nutrition and hydration or pregnancy." *Id.* In fact, the Health Care Decision Act not only includes language regarding advance directives, it includes all medical decisionmaking even if an advance directive is not executed. The patient may also designate a healthcare agent to make any treatment decisions for the incapacitated patient. Health Care Decision Act, 7(b). Further, recognizing the vulnerability of patients confined to long-term residential healthcare facilities, the Health Care Decisions Act precludes owners, operators or employees of such facilities from serving as agents unless they are related to the resident by blood, marriage or adoption. *Id.* at §2(b). With respect to the validity of sister-state advance directives, the Health care Decisions Act simply states that if an advance

directive complied with the Health Care Decisions Act, it is valid regardless where it was executed. *Id.* at §2(h).

The Commission's approach makes an important point: the autonomy of the patient and the patient's ability to communicate with his or her doctor and any health care decisions made as a result of this communication must be honored. The Commissioners also serve as an example to this Court where one body, expert in the area of advance directives, can draft model legislation that can serve as a template for individual state legislatures.

D. The *Oregon Death With Dignity Act* And The *Australian Rights Of The Terminally Ill Act* Are Examples Of Existing Legislation On This Issue.

Currently, few statutes anywhere in the world specifically authorize physicians to assist patients in ending their lives. Two of these statutes are the Oregon Death With Dignity Act, Ore.Rev.Stat. ch. 127.800 §1.01 *et seq.* (1995) ("Oregon Act"), and the Northern Territory of Australia Rights of the Terminally Ill Act ("Australian Act"). Each provides substantial protection for patients and physicians.

The Oregon Act, passed in November 8, 1994, is the first American statute permitting and regulating treatment intended to end life.[7] The Oregon Act provides, *inter alia*, that (i) a witness to any advance directive regarding end-of-life treatment, executed by a patient in a long-term facility, must be an "individual designated by the facility [who] has the qualifications specified by the Department of Human Resources;" (ii) patients must be made aware of feasible alternatives including comfort care, hospice care and pain

7 In *Lee v State*, 86 F.Supp. 1491, 1493 (D.Or. 1994), the district court imposed a preliminary injunction, ruling that substantial constitutional issues need be resolved before the Oregon Act may be implemented. This statute, nonetheless, provides an interesting model for the regulation of treatment intended to end life.

control; and (iii) if a physician believes that the patient is suffering from a psychiatric or psychological condition or depression impairing the patient's judgment, the physician shall request that the patient be referred to counseling. Ore.Rev.Stat. ch. 127.810 §2.02(4); ch. 127.815 §301(e); and ch. 127.875 §303 (1995). The Oregon Act, however, fails to address the use of ethics/oversight committees specializing in the treatment of terminally-ill patients -- a proposal that ACLM feels is vitally important.

The Australian Act, on the other hand, is significantly more comprehensive. Under the Australian Act: (1) palliative care options must be made available to the patient, and if this care can bring about a remission in the patient's pain and suffering, the physician shall not assist the patient in ending life; (2) medical treatment is to be confined to the relief of pain and suffering, with the object of allowing the patient to die comfortably; (3) two additional physicians, other than the primary physician, one being a psychiatrist, must examine the patient to determine that the patient's request is not premised upon treatable clinical depression; (4) the physician must be satisfied that the patient has made an informed decisions and has not been coerced to end life; (5) at least 48 hours must elapse between the time the patient requests and the physician provides treatment that will hasten the patient's death; and, (6) the physician must be guided by appropriate medical standards and pharmacological guidelines, and the physician must remain with the patient while assistance is given, and until the death of the patient.

Debate over the Australian statute is far from over. Australia's legislature is now considering a bill entitled *Care of the Dying Consultation Bill*, which would create a committee designed to address the following issues: (a) the extent to which both the health services and the present law provide adequate options for dying with dignity; (b) whether there is sufficient public and professional awareness of pain relief and palliative care available to persons facing prolonged

pain in a terminal illness; (c) whether there is adequate provisions of pain relief and palliative services to persons facing prolonged pain in a terminal illness; (d) whether there is sufficient public and professional awareness of the [country's] *National Death Act* and, if not, what measures should be taken to overcome any deficiency; (e) to what extent, if any, community attitudes towards death and dying may be changing; and (f) to what extent, if any, the law relating to dying needs to be clarified or amended. *See Northern Territory of Australia, Care of the Dying Consultation Bill* (1996).

ACLM believes that regulations regarding treatment decisions intended to end life cannot exist without a structure that has the ability to oversee and evaluate the treatment process, as well as to provide for extensive education of the public regarding the options available to terminally ill patients. Clearly, discussions regarding legal and public policy issues attendant to end-of-life treatment decisions will be ongoing. Nevertheless, the gauntlet is laid. Numerous comprehensive regulations on end-of-life medical treatment imposed by federal and state statutes, as well as by the healthcare community itself, not only exist, but also effectively allow for the responsible administration of end-of-life treatment and care. In fact, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. To the extent they would not so apply, these laws and protocols provide a framework upon which applicable regulations can and should be crafted.

III. The Right To Treatment Intended to End Life Is Consistent With Traditional Notions Of Liberty-Based Rights Secured By The Due Process Clause

In this appeal, petitioners challenge the Second and Ninth Circuit's rulings that the state statutes in question in each of these cases are unconstitutional. The Second Circuit found the New York statute unconstitutional on equal protection

grounds, whereas the Ninth Circuit invalidated the Washington statute as an impermissible deprivation of a patient's liberty rights, *i.e.*, substantive due process rights. As stated *supra*, ACLM questions whether these statutes -- which criminalize promoting or assisting in suicide -- even apply to the situation in which a physician provides treatment intended to end life for a mentally-competent adult in the end-stages of a terminal illness, because arguably, the act in question here is not suicide. Petitioners, however, clearly believe that it is. Assuming *arguendo* the accuracy of that position, ACLM asserts that patients fitting the qualifications repeated throughout this brief are constitutionally-entitled to seek treatment intended to end life under the due process clause of the Fourteenth Amendment. That right, however, like most all rights, is not absolute, and must be appropriately regulated to avoid abuse, particularly in light of the seriousness of abuse in this context, *i.e.*, the potential promotion of patient suicide. Accordingly, ACLM asserts that the subject statutes are unconstitutional *to the extent* that they criminalize, *per se*,[8] treatment intended to end the life of a mentally-competent adult in the end-stages of a terminal illness.

A. The Supreme Court Has Long-Recognized An Individual's Right to Personal Autonomy and Bodily Integrity, Which Principles Underlie The Right Sought By Respondents.

ACLM's position is premised, certainly, upon its belief that the subject treatment should be available for "qualified" patients who seek it. But ACLM's position is also supported by, and consistent with, a long line of Supreme Court decisions which secure the rights of individuals to be free

---

8 ACLM does not contend that the subject statutes are unconstitutional to the extent that they criminalize promoting or assisting in suicide generally, but rather, ACLM asserts that they constitute an impermissible infringement on the rights of a mentally-competent adult in the end-stages of a terminal illness to seek from a physician medical treatment intended to end life.

from undue governmental intrusion in the most personal, intimate choices that go to the essence of personhood, personal autonomy and self-determination. For example, in 1891, the Supreme Court decreed that:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); *see also* Justice Benjamin Cardozo's opinion in *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

The venerable Justice Louis Brandeis echoed this principle nearly four decades later *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("[t]he makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness ... [t]hey sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations ... [t]hey conferred ... the right to be let alone -- the most comprehensive of rights and the rights most valued by civilized men").

As Justice O'Connor noted, concurring in *Cruzan*, "[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." 497 U.S. 261, 287. Not only has this Court long-protected an individual's bodily integrity, it also has expressly (a) confirmed the existence of a right (based in Fourteenth Amendment liberty interests) of an individual to make life and death decisions, and (b) recognized the potential for abuse of

that right, acknowledging the need for appropriate state regulation:

> The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe [the state] may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. In cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, "there will, of course, be some unfortunate situations in which family members will not act to protect a patient." A State is entitled to guard against potential abuses in such situations.

Cruzan, 497 U.S. 261, 281 (citations omitted).

Most recently, this Court articulated its respect for personal autonomy in making life's most personal decisions:

> It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. * * * * * These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 847, 851 (1992) (citations omitted).

There can be no decision in life more personal, more intimate, and more warranting of constitutional protection than that of a terminally-ill patient contemplating whether to live under the burden of disease, pain and indignities, or to accede to mortality when death is at the door. Moreover, this position is hardly unique to ACLM; it underlies each of the federal appellate decisions at issue here:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Quill, 80 F.3d at 727 (citation omitted).

> [T]he decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice "central to personal dignity and autonomy." A competent terminally-ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying, 79 F.3d at 813-814.

Under this weighty precedent, and under the language of the distinguished panels of the Second and Ninth Circuits, ACLM asserts that there is ample foundation on which to recognize and protect the liberty interests of a mentally-

competent adult in the end-stages of a terminal illness to obtain care and treatment intended to end life.

Finally, ACLM recognizes and supports the Second Circuit's decision in *Quill*, which, too, recognizes the constitutional right of "qualified" patients to seek medical treatment intended to end life -- a decision based on equal protection, rather than due process, grounds. The Second Circuit's decision, however, is squarely-premised upon its finding that there is no relevant distinction between the withdrawal or withholding of life-support systems and treatment with the intent to hasten death, on the one hand, and the administration of drugs with the intent to hasten death, on the other hand. While ACLM agrees, believing both acts to be medical treatment intended to end life, ACLM also recognizes that there is room for reasonable debate and disagreement with respect to that distinction. Because the right sought herein is fundamental to those principles of liberty secured under the Fourteenth Amendment, ACLM believes the right should be recognized under the Due Process Clause.

B. ACLM's Position Does Not Infringe Upon The Integrity Of The Medical Profession.

ACLM -- an organization led by and including numerous physicians -- asserts that its position in no way infringes upon the integrity of the medical profession. Those who argue otherwise, most notably the *Compassion in Dying* petitioners and the AMA, contend essentially that a physician is barred from assisting in the termination of life under any conditions due to his or her obligations imposed by the Hippocratic Oath. The Ninth Circuit cleanly disposed of this contention. Noting that the identical argument was asserted in *Roe v. Wade* and *Cruzan*, in opposition to the rights sought in those cases, the Ninth Circuit stated that the Oath was not even accepted by all physicians at the time it was created. 79 F.3d at 829. Moreover, the Oath hardly "represent[s] the best or final word

on medical or legal controversies today." *Id.* Finally, to impose upon American jurisprudence the dictates of the Oath would, arguably, not only preclude a physician, in all situations, from performing an abortion, from terminating life-support and from providing treatment intended to end life, it would furthermore preclude a physician from engaging in surgery. *Id.* Clearly, American law should not rely upon the Hippocratic Oath in constitutional interpretation.

Finally, ACLM fully acknowledges and supports an individual physician's right to decide whether to provide care and treatment intended to end life. The physician who finds religious, moral or ethical reasons not to provide such treatment certainly need not do so. ACLM asserts, however, that, as shown in *Roe* and *Cruzan*, this option of the individual physician should not bar "qualified" patients from exercising a constitutional right to seek such treatment.

C. The Treatment At Issue Here Is Consistent With Treatment Long-Provided By Physicians.

In *Compassion in Dying*, the State of Washington argued to the Ninth Circuit that it was appropriate to draw a distinction between, on the one hand, a physician prescribing medication for the *sole purpose* of hastening death -- behavior, the state argued, is and should be criminalized -- and on the other hand, a physician prescribing medication for the *dual purposes* of alleviating pain and hastening death -- behavior, the state argued, is appropriate and lawful. 79 F.3d at 823.

In this regard, ACLM confirms the Ninth Circuit's understanding that, for decades, physicians have routinely and openly provided medication to terminally-ill patients with the knowledge that the drug will have the dual effect of reducing pain and hastening death. 79 F.3d at 823. If, however, this practice is to remain lawful, as the State of Washington and the AMA argue it should, then it is wholly inconsistent to argue that "sole purpose" treatment must remain unlawful. It

defies logic to contend that the physician, who prescribes a drug that will alleviate pain and hasten death, is a merciful healer, while the physician, who prescribes a drug that will hasten death and thereby eliminate pain, is a punishable felon. *See also* 79 F.3d at 823 n. 95. Under common medical practice of the day, this inconsistent result would be realized by upholding the subject statutes in their entirety.

IV. Conclusion

ACLM began this brief with the words of Seneca uttered over twenty centuries ago. His words are prophetic and instructive, because he contemplates the instinctive zest for meaningful life, while acknowledging the pointless despair resulting from physical deterioration. Indeed, risks exist in recognizing the right of competent adults in the end-stages of a terminal illness to determine the time and manner of their death; but safeguards, crafted and imposed by government and by the healthcare community, will minimize the threat of abuse and assuage societal fears. With appropriate protocols, we must take and overcome these calculated risks to secure human dignity and personal autonomy in death. Sherwin B. Nuland, M.D., in his book, *How We Die* (Vintage 1995), ties this notion to the words of Seneca:

> All of this is not to say that there are no situations in which Seneca's words deserve heeding. But should this be so, the Roman's doctrine would then deserve consultation, counsel, and the leavening influence of a long period of mature thought. A decision to end life must be as defensible to those whose respect we seek as it is to ourselves. Only when that criterion has been satisfied should anyone consider the finality of death.

Nuland at 152. Criteria and protocols are, indeed, the watchwords of the day.

Moreover, ACLM is mindful of the vast benefits of advancements in medicine and technology; but science not only prolongs life, it concomitantly prolongs misery, pain and suffering. With this in mind, we ought not be driven by medical advancement to the disregard for the rights of terminally-ill patients, such as those on whose behalf the instant cases were brought. ACLM recommends to this Court the Nuland book (*supra*), and especially the story of the final days, in 1961, in the life of Harvard Physicist and Nobel Laureate, Professor Percy Bridgman. A colleague remembers Bridgman, then suffering from terminal cancer, deploring the need to end his own without assistance:

> I would like to take advantage of the situation in which I find myself to establish a general principle: namely, that when the ultimate end is as inevitable as it now appears to be, the individual has a right to ask his doctor to end it for him.

Nuland at 152-153. The message Seneca conveys and the words of Professor Bridgman, though separated by over 2000 years, are very much alike. The similarity shows a constancy in the human spirit and the quest for autonomy and dignity, existing long before and lasting long after our founding fathers incorporated this notion of liberty into the Constitution.

The cases before this Court involve, first and foremost, particular patients and their sacrosanct relationship with their caregivers. That that relationship serves the best interests of a patient, as well as society, is perhaps evidenced best by the graphic and compelling description of the death of an AIDS patient as recounted by his physician, one of the plaintiff physicians in *Compassion in Dying*:

> One patient of mine ... lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. ... [F]riends stopped visiting him because it gave them nightmares. [The patient's] agonies could not be relieved by medication or by the excellent care he received. [He] begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that [the patient] was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the [State of Washington] statute, I was unable to assist him and he died after having been tortured for weeks by the end phase of his disease.

79 F.3d at 814. **American jurisprudence should not countenance suffering of this nature; an individual's Fourteenth Amendment liberty-rights do not allow for it.**

"Contemporary times demand contemporary, thoughtful and humane responses to the critical issue of terminally ill patients, not lock-step repetition of past follies." Smith, *supra* at 355. ACLM proposes such a contemporary, thoughtful and humane response.

Respectfully submitted,

AMERICAN COLLEGE OF LEGAL MEDICINE

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APPENDIX A

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October 18, 1996

Mr. Miles J. Zaremski
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102 North LaSalle Street Suite 1800
Chicago, Illinois 60601-1293

Re: *Washington v. Glucksberg*,
U.S. Supreme Court Cause No. 96-110

Dear Mr. Zaremski:

This responds to your letter of October 14, 1996, requesting consent to file a brief as *amicus curiae* in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Very truly yours,

WILLIAM L. WILLIAMS
Sr. Assistant Attorney General

WLW:am

cc: Kari A. Smith

APPENDIX A-1

CONSENT TO FILING BRIEF *AMICUS CURIAE*

No. 95-1858

IN THE SUPREME COURT OF
THE UNITED STATES

October Term, 1995

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

Consent to File Brief *Amicus Curiae*

Miles J. Zaremski, Esq.
Rudnick & Wolfe
203 North LaSalle St., Suite 1800
Chicago, Illinois 60601-1293

Pursuant to Rule 37, Petitioners Dennis C. Vacco, Attorney General of the State of New York, and George E. Pataki, Governor of the State of New York, hereby consent to the filing in this matter on behalf of the American College of Legal Medicine of a brief amicus curiae.

Barbara G. Billet
Solicitor General
State of New York
Office of the Attorney General
120 Broadway
New York, New York 10271

DISTRICT ATTORNEY
OF THE
COUNTY OF NEW YORK
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ROBERT M. MORGENTHAU
District Attorney

October 17, 1996

Miles J. Zaremski
Rudnick & Wolfe
203 North LaSalle St. Suite 1800
Chicago, IL 60601-1293

Re: Vacco v. Quill
No. 95-1858

Dear Mr. Zaremski:

Pursuant to my conversation with Lucia M. Valente, Chief Special Counsel to the Attorney General of the State of New York, this confirms that District Attorney Robert M. Morgenthau consents to the appearance of the "American College of Legal Medicine" in the above matter as an amicus curiae under Rule 37.3(a). If you require such consent in a different form please so advise.

Respectfully,

Robert M. Morgenthau
District Attorney
New York County
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(212) 335-9000

By: Marc Frazier Scholl
Marc Frazier Scholl
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October 18, 1996

Miles J. Zaremski
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203 North LaSalle Street
Suite 1800
Chicago, IL 60601-1293

Re: *State of Washington v. Glucksberg*, No. 96-110;
Amicus Participation

Dear Mr. Zaremski:

This letter replaces the consent letter sent to you on October 16, 1996.

This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,

Kathryn L. Tucker

KAS:rak

cc: William L. Williams

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October 18, 1996

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Re: *Vacco v. Quill*, No. 95-1858;
Amicus Participation

Dear Mr. Zaremski:

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This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,

Kathryn L. Tucker

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cc: Lucia M. Valente, Esq.

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APPENDIX B

March 1996

State Statutes Governing Living Wills and Appointment of Health Care Agents



Jurisdictions with legislation that authorizes both living wills and the appointment of a health care agent (**the District of Columbia and 45 states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming**)

States with legislation that authorizes only living wills (**2 states: Alabama and Alaska**).

States with legislation that authorizes only the appointment of a health care agent (**3 states: Massachusetts, Michigan and New York**).

Note: The specifics of living will and health care agent legislation vary greatly from state to state. In addition, many states also have court-made law that affects residents' rights. For information about specific state laws, please contact Choice In Dying.

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APPENDIX B-1

APPENDIX C

AMERICAN HOSPITAL ASSOCIATION

Policy and Statement

PATIENT'S CHOICE OF TREATMENT OPTIONS

POLICY

Health care decision making should be based on a collaborative relationship between the patient and the physician and/or other health care professionals who are primarily responsible for the patient's care.* The collaborative framework encourages communciation, which contributes to sound decision making. Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patient, who may choose to delegate it. In the hospital setting, institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficiently voluntary and informed decision. In addition, the health care institution should have methods to identify

*The term *physician* is used throughout the document, although other health care professionals may be responsible for or authorized to provide patient care.

This policy and statement was developed by the Special Committee on Biomedical Ethics, which had been established by the General Council in January 1983 to consider various aspects of biomedical ethical issues facing the health care field.

This document replaces the *Guidelines on the Right of the Patient to Refuse Treatment* that was approved in 1973. The House of Delegates approved the policy and statement in February 1985.

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circumstances under which the patient's authority may be constrained, and recourse to the judgment of others, including the courts, is appropriate.

STATEMENT

The right and responsibility to select among treatment options** presumes that the patient is capable of consulting with the physician about and understanding the available treatment alternatives and their implications and making a choice. Consultation might also take place with other responsible or authorized health care professionals involved in coordinating the patient's care. This process requires the patient's adequately-informed consent and may involve an evaluation of the patient's capacity to make a decision.

Collaborative Decision-Making

Informed consent should reflect shared or collaborative decision making by the patient and the physician. The physician should provide information on the patient's condition, the recommended procedure and/or treatment with its significant benefits and risks, the significant alternative for care or treatment (including no specific treatment), and the likely duration of incapacitation, if any.† Because patient's understanding of this information is essential to informed consent, care should be taken to present it in language familiar to them. Although institutional policy should promote documentation of consent decisions, such documentation is evidence of but not a substitute for communication and understanding between patient and physician. Unless the physician believes the patient would object, it may be advisable and

---

**For the purpose of this document, treatment can be interpreted to include diagnostic as well as therapeutic procedures.

†See the AHA Policy on *A Patient's Bill of Rights*.

useful if this information is shared with the patient's family, which often is a valuable resource for both the patient and the physician. Health care institutions and professionals should see to it that patients have access to understandable information relevant to the treatment choices before them.

In cases where the patient has chosen to delegate the treatment choice selection to the physician or someone else, a discussion with the patient about the implications and ramifications of the treatment course to be pursued is still recommended. Often family and friends should be included in this discussion.

In some emergencies, obtaining voluntary and adequately informed consent may not be possible or may be detrimental to the patient's well-being. In such cases, the patient's consent to the course of treatment chosen by a physician may be legally implied from the urgent circumstances surrounding the provision of that care.

Implications of Treatment Choice

The right to choose treatment includes the right to refuse a specific treatment or all treatment, or select an alternative form of treatment. If the patient decides to refuse all treatment, a written informed refusal is strongly recommended to protect the hospital, the physicians, and all other personnel from liability, if any, for failure to furnish treatment. This decision should also be documented on the patient's chart.

If a patient chooses a course of treatment that is not acceptable to the attending physicians or other health care professionals, those individuals may withdraw from the case, so long as doing so does not amount to legal abandonment. If a suitably qualified alternative physician or health care professional willing to comply with the patient's preference is available, transfer to the care of that individual should be offered to the patient. If no physician or qualified health care

professional is willing to undertake the patient's choice of treatment, the hospital should have a policy to address what procedures relative to care of the patient should be followed. The hospital also should have a policy to help identify and address those situations when the course of treatment selected is unacceptable to the mission of the institution.

Laws regarding the right of a patient or someone on the patient's behalf to refuse treatment vary from state to state. Some state laws limit a patient's right to refuse treatment, and others make provisions to facilitate the exercise of this right. The hospital's and the physician's response to a refusal, whether action or nonaction, must be consistent with applicable law. If a refusal can potentially result in substantial detriment to the patient's health and well-being, institutions should require that the appropriate administrative authority be informed. Protection of the patient's authority to select treatment at times may require either legal counsel or judicial proceedings.

Decision-Making Capacity

Decision-making capacity is the ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions. Attention should be paid to the difference between decision-making capacity and legal competency. Decision-making capacity may exist, as in the case of a minor, where no legal competency exists. Legal competency may exist where decision-making capacity does not, as in the case of a temporarily impaired adult who has not been deemed legally incompetent. In health care treatment decisions, decision-making capacity is best understood as the patient's ability to understand the nature and effects of treatment options, and appreciate the impact of a choice. Only when the patient's capacity to make decisions is definitely impaired and the effect of flawed decision making

is potentially serious should the patient's right and responsibility for decision making be transferred to others.

When there is reason to doubt the usual presumption of adequate decision-making capacity, an assessment of capacity is made by the physician in consultation with the family, friends, nurses, and other health care professionals. The institution should have effective policies to facilitate assessment of patients' decision-making capacity. The institution should have methods to ensure that the physician conducts these assessments when necessary. The hospital should also see to it that there are accessible and practical avenues by which concerns about a patient's capacity to make decisions may be raised by others, including family, friends, nurses, and other health care professionals. The hospital may also wish to have a policy under which a patient, in appropriate circumstances, should be informed both of any concerns raised by the assessment and of access to procedures for reassessment or to legal counsel. Only when the determination regarding decision-making capacity is controversial among concerned persons (including the patient) should legal guardianship proceedings be required.

When a patient lacks adequate decision-making capacity, substantial effort should be made to ensure that the choice of medical treatment is consistent with the known views of the patient. The decision makers must seek and take note of any information reflected in oral statements, life-style commitments, living wills, and so forth made by the patient before deterioration of decision-making capacity. These known views can sometimes be supplied by the family or an individual acting as surrogate. The surrogate should be a person or group of persons most likely to be able to advocate on the patient's behalf and to assess the patient's preferences and experiences. If the physician knows through informal communications, durable power of attorney, or living will of the patient's designation of a surrogate, that person should serve unless mitigating factors are apparent.

If the selection of the surrogate seems controversial, methods for institutional review and, if necessary, court adjudication are required. In some cases, court appointment of a surrogate may be legally required. The institution should be prepared to refer difficult cases to court for guardianship determinations.

Role of Minors in Decision-Making

Patients who are minors should be allowed to participate in decision-making about their care to the extent possible with regard to their capacity to understand treatment options and outcomes. When a minor is deemed legally incapable of making a decision, that is, not considered to be a "mature" or "emancipated" minor according to state law, the parent or legal guardian usually will have the final decision-making authority. Mature or emancipated minors, as determined by state law, should be treated as adults with decision-making capacity.

Institutions should establish policies concerning the circumstances under which legal advice is to be sought for either the institution or the minor, including cases where a parent or guardian makes a decision that may be deemed adverse to the interests of a minor or opposed to the expressed views of a relatively mature minor.

Management Practices and Procedures

Hospitals have a responsibility to assess the effect of management practices and procedures on patient decision-making options and to foster awareness among health care professionals and key hospital personnel that some institutional practices necessary to ensure efficiency, such as some admissions or food service procedures, can unintentionally limit patient choices. For example, the patient often does not have the opportunity to make many of the routine choices in day-to-day living—when to have meals, wake up, have visitors, etc.

Documentation of Decision-Making

Documentation of decisions regarding patient treatment promotes orderly procedures and more thorough consideration of options. Documentation also provides legal protection for and is often in the best interests of patients, patients' families, concerned health professionals, and hospitals.

Conclusion

The patients' role in determing the course of their medical treatment must be ensured in the institutional setting. Although these decisions should be made in collaboration with the attending physicians, the hospital must take a leadership role in ensuring institutional practices that support patients' decision making and in identifying when recourse to the judgment of others is necessary.

(31) (24)

No. 95-1858 and No. 96-110

Supreme Court, U.S.
FILED
NOV 12 1996
CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ET AL.,
PETITIONERS,
v.
TIMOTHY E. QUILL, ET AL.,
RESPONDENTS.
and
STATE OF WASHINGTON,
PETITIONERS,
v.
HAROLD GLUCKSBERG, ET AL.,
RESPONDENTS.

On Appeal from the United States Courts of Appeals for the Second Circuit and Ninth Circuit

BRIEF FOR BIOETHICS PROFESSORS AMICUS CURIAE SUPPORTING PETITIONERS

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November 12, 1996

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QUESTIONS PRESENTED

Is there a difference between the constitutional right of a competent adult to refuse medical treatment, including life-sustaining medical treatment, and the right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

Does the constitutional right of a pregnant woman to terminate a pregnancy by a physician-performed or prescribed medical procedure support a constitutional right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

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In the
Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858 and No. 96-110

DENNIS C. VACCO, ET AL.,
PETITIONERS,

v.

TIMOTHY E. QUILL, ET AL.,
RESPONDENTS.

and

STATE OF WASHINGTON,
PETITIONERS,

v.

HAROLD GLUCKSBERG, ET AL.,
RESPONDENTS.

On Appeal from the United States Courts of Appeals for the Second Circuit and Ninth Circuit

BRIEF FOR BIOETHICS PROFESSORS AMICUS CURIAE SUPPORTING PETITIONERS

Interest of Amicus

Amicus is an ad hoc group of 50 professors who teach medical ethics to medical students and/or physicians in universities, medical schools, and clinical settings. The Amicus professors include philosophers, theologians, attorneys, and physicians of different religious backgrounds who have a major professional interest in medical ethics. The Amicus group strongly believes that permitting competent adults to refuse any medical treat-

ment is a fundamental right consistent with medical ethics, is independent of any purported right to physician assisted suicide, and should continue to be protected by the Court. The Amicus group also strongly believes that a woman's constitutional right to decisionmaking regarding abortion in the privacy of the physician-patient relationship should continue to be protected independent of any purported right to physician assisted suicide. Amicus has obtained the written consent of the parties in both actions to filing this brief. (Letters confirming the parties' consent have been filed with the Clerk of the Court.)

Summary of Argument

I

The analytical basis for both the Ninth and Second Circuit Courts of Appeals opinions is that there is no difference between the right of all competent people to refuse recommended medical treatment and the right to physician assisted suicide. There are, however, major differences between the right to refuse medical treatment and the right to physician assisted suicide. The right to refuse treatment is rooted in the history and traditions of this country. It is the expression of the venerable and universally recognized right of all individuals to be free from unwanted and nonconsensual physical invasions of their bodies. All courts that have decided the issue until now have readily distinguished between suicide and refusing treatment, and have permitted the refusal of medical treatment while still recognizing the state's interest in the prevention of suicide.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize both constitutional and common law rights to refuse treatment.

II

The Ninth Circuit Court of Appeals' decision derived the

right to physician assisted suicide from the Court's cases that recognize a woman's constitutional right to decide whether or not to terminate her pregnancy. This is mistaken because those cases are specifically directed at enabling a woman to make choices she believes further her health and continued participation in society, whereas assisted suicide leads only to death.

If it is true that people have the constitutional right to commit suicide and, therefore, the constitutional right to assistance in their suicide, there is no reason why this right is limited to assistance from physicians. Unlike abortion, neither suicide nor assisted suicide is a medical procedure.

There is no basis in logic or constitutional law to limit the right to assisted suicide to terminally ill patients. There is no accepted definition of terminal illness, and it is difficult, if not impossible, for physicians to accurately predict any particular individual's life expectancy.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize a woman's constitutional right to decide whether or not to terminate a pregnancy.

Argument

I. THE RIGHT OF A COMPETENT INDIVIDUAL TO REFUSE MEDICAL TREATMENT IS UNIVERSALLY RECOGNIZED, IS DEEPLY ROOTED IN THE HISTORY AND TRADITIONS OF THE UNITED STATES AND HAS NEVER BEFORE BEEN EQUATED WITH SUICIDE BY AN APPEALS COURT OR A LEGISLATURE.

A. *The Right of a Competent Individual to Refuse Medical Treatment is Universally Recognized and Deeply Rooted in the History and Traditions of the United States.*

The major premise upon which both the Ninth Circuit Court of Appeals in *Compassion in Dying* v. *Washington*, 79

F.3d 790 (9th Cir. 1996), and the Second Circuit Court of Appeals in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), rely to find that there is a constitutional right to physician assisted suicide is that there is no rational distinction between physician assisted suicide and the right of an individual to refuse life-saving medical treatment. This premise is not only incorrect, but threatens the well established right to refuse treatment.

The Ninth Circuit Court of Appeals mistakenly believes that the right of individuals to refuse treatment is a modern invention that was only recently bestowed upon individuals by the courts. It states, "The first major breakthrough occurred when the terminally ill were permitted to reject medical treatment." 79 F.3d at 821, citing *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). The Ninth Circuit Court of Appeals refers to the recognition of the rights of individuals both to refuse and to terminate medical treatment, as "drastic changes regarding acceptable medical practice. . . ." 79 F.3d at 822. To reach this conclusion, the court must have believed that until the 1970's the law permitted patients to be forcibly treated. This demonstrates a profound misunderstanding of the source and application of the right to refuse treatment. It was not until 1912 "when for the first time in human history . . . a random patient with a random disease consulting a doctor chosen at random stood a better than 50-50 chance of benefiting from the encounter." RICHARD HARRIS, A SACRED TRUST 5 (1966). Since medicine had little effective treatment to offer prior to this century, there was no reason to ever attempt to force treatment on patients. When the consent issue did come before courts, their decisions were clear. In 1905, for example, an Illinois court held:

> Under a free government at least, the free citizen's first and greatest right which underlies all others — the right to the inviolability of his person, in other words, his right to himself — is the subject of universal acquiescence, and

> this right necessarily forbids a physician . . . to violate, without permission, the bodily integrity of the patient by a major or capital operation.

Pratt v. *Davis*, 118 Ill. App. 161 (1905), *aff'd* 224 Ill. 300, 79 N.E. 562 (1906).

Similarly, in a 1914 New York case, Justice Brandeis wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

The principles of bodily integrity and self-determination are so basic that they seem to need no justification. Nothing empowers the state to require a free living, competent adult to always comply with medical advice. Such a rule would convert medical advice into medical tyranny. One searches in vain to find a case in which free living competent adults are restrained against their will and forced to submit to treatment by physicians. The law is entirely in the other direction — competent adults are under no legal obligation to submit to offered treatment. The laws of battery and informed consent are barriers against unwanted treatment. *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied* 409 U.S. 1064 (1972).

The case law throughout the United States is consistent and unequivocal: competent adults have the right to refuse any medical treatment, and the exercise of this right is not contingent on suffering from a terminal illness. In *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978), for example, a 72-year-old man refused to have his gangrenous legs amputated. He was not terminally ill or comatose. He could live indefinitely if he submitted to the recommended treatment but would soon die if he refused the treatment. The court found that this competent man could refuse such life saving treatment. Similarly, in *Lane* v. *Candura*, 6 Mass. App. Ct. 373, 376 N.E.2d 1232 (1978), the Massachusetts appeals court

found that a competent 77-year-old woman could refuse a life-saving amputation of her foot. She was not terminally ill and could live indefinitely if the procedure were performed. As the court concluded, "we are all of the opinion that the operation may not be forced upon her against her will." 6 Mass. App. Ct. at 384, 376 N.E.2d at 1236.

Failure to honor this right leads to horrific consequences. William Bartling, a 70-year-old man who was suffering from five potentially fatal illnesses, was so insistent on refusing treatment that he had removed his ventilator himself on several occasions. In response, the physicians ordered his hands tied to his bed. The trial judge ruled that his ventilator could not be removed because Mr. Bartling was not terminally ill, comatose, or brain dead. Since none of these conditions are prerequisites for treatment refusal, the California Court of Appeals reversed. It ruled that a competent adult could refuse any treatment, including life-sustaining treatment, and that the act of removing a ventilator at the patient's demand was no different legally from not attaching a ventilator in the first place. *Bartling* v. *Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984). No competent person should ever be forcibly treated in this country, and appellate courts have consistently confirmed this principle.

The principle of consent with its complementary right to refuse and withdraw consent is fundamental. How could it be otherwise? What power could be called upon that would permit the state to forcibly amputate the limbs of competent people? Certainly the *parens patriae* power does not apply to competent people, and the police power does not apply where the person's decision only affects him- or herself.[1] Absent

[1] There is no doubt that the state, in the exercise of its police powers, has the authority to limit the exercise of an individual's autonomy for the purpose of protecting the public's health. *See, Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). But even in that case, the Court did not rule that Jacobson could be forcibly vaccinated. Rather it held that he could be fined for failure to comply with the city's mandatory vaccination order. Those who suffer from contagious diseases, such as tuberculosis, and who refuse treatment that would render them noninfectious can be isolated from the general population. *Greene* v. *Edwards*, 164 W.Va. 326, 263 S.E.2d 661 (1980).

the right to refuse medical treatment, all persons would be required to submit themselves to any treatment a physician recommends. It is estimated that approximately 70 percent of the deaths in hospitals today follow some decision to withhold or to stop treatment. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 147 (1994). In an era in which most people die in hospitals or nursing homes, this opens the possibility of all patients being forcibly subjected to an unlimited onslaught of medical interventions at the end of life. Nothing in American law permits this absent patient consent.

This Court has recognized the individual's strong interest in avoiding unwanted treatment. The Court noted, "The *forcible injection of medication* into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington* v. *Harper*, 494 U.S. 210 (1990) (emphasis added). In *Cruzan* the Court stated "The principle that a competent person has a constitutionally protected liberty interest in refusing *unwanted medical treatment* may be inferred from our prior decisions." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), 497 U.S. at 278 (emphasis added). Justice O'Connor, in her concurring opinion, said, "Requiring a competent adult to endure *such procedures against her will* burdens the patient's liberty, dignity and freedom to determine the course of her own treatment." 497 U.S. at 289 (emphasis added).

The belief of both Circuit courts that there was a time in American law when a competent individual could not refuse medical treatment may come from a misreading of a few cases from the 1960s that involved Jehovah's Witnesses who refused blood transfusion as a result of their religious beliefs. The patients involved were not terminally ill and would likely

recover and live long, healthy lives if this relatively minor physical intrusion was allowed.

Perhaps the most widely cited of these cases is *Application of the President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964). In this case, a 25-year-old woman was brought to the hospital with a bleeding ulcer, having lost two-thirds of her blood. Both the patient and her husband were Jehovah's Witnesses. The judge spoke to the husband, and wrote, "He advised me that on religious grounds he would not approve a blood transfusion for his wife. He said, however, that if the court ordered the transfusion, the responsibility was not his." When the judge went to the patient's room he found that "It was obvious that the woman was not in a mental condition to make a decision." The judge asked her if she would oppose a transfusion if he authorized it and reported, "She indicated, as best I could make out, that it would not then be her responsibility." The judge then authorized the blood transfusions. This is not a case of *forcible* treatment being inflicted on a competent patient. Rather it is a case in which neither the incompetent patient nor her husband could consent to the blood transfusion because of their religious beliefs, but made it clear to the judge that they did not oppose his authorization of the treatment. The patient and her husband were relieved to have the judge make this decision for them.[2]

United States v. *George*, 239 F.Supp. 752 (D. Conn. 1965),

[2] Although a petition for a rehearing *en banc* was denied for technical reasons, a number of judges expressed the opinion that the single judge who decided this case had no authority to do so, and that if he did have such authority, his decision was wrong. 331 F.2d at 1010. Circuit Judge (later Chief Justice) Burger asks in his opinion, "If the patient has objections to that treatment based on religious conviction, or if he rejects the medical opinion, are the courts empowered to decide for him?" 331 F.2d at 1017. He later answers this question by stating, ". . . there are myriads of problems and troubles which judges are powerless to solve; and this is as it should be. Some matters of essentially private concern and others of enormous public concern, are beyond the reach of judges." 331 F.2d at 1017-18.

is similar. In this case the judge explained that he had no power to *order* the transfusion and that the patient would be free to resist the transfusion by merely putting his hand over the site where the needle would be inserted. The patient responded he would in no way resist the transfusions once the judge signed the order. Again, this is the case of a person who could not affirmatively consent to a transfusion because of his religion, but who did not oppose being treated.

These cases can be compared to *In re Osborne*, 294 A.2d 372 (D.C. App. 1972), in which a 34-year-old father who was seriously injured in an accident refused a life-saving blood transfusion. Mr. Osborne told the judge, "It is between me and Jehovah, not the courts . . . I'm willing to take my chances. My faith is that strong. I wish to live but with no blood transfusions." No transfusion was authorized in this case.[3]

Far from supporting governmental authority to violate the bodily integrity of competent individuals, these cases demonstrate the respect judges have traditionally shown for individual autonomy in regard to the receipt or refusal of medical care. They have enabled those who wish to receive such care to obtain it, and have protected the bodily integrity of those who did not wish to receive the offered care.

The right defined and protected in all the right to refuse treatment cases is the right to be free from unwanted bodily intrusions. It is not the "right to die" or to determine "the time and manner of one's own death" or to "hasten" one's death.

[3] Other cases in which individuals were found to have the right to refuse life-saving blood transfusions include *Matter of Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (1976) (23 year old woman could refuse blood transfusion to save her life); *Erickson* v. *Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962) (adult patient has the right to refuse a blood transfusion his doctor said was necessary to save his life); *In re Brooks' Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965) (patient may refuse blood transfusion where the decision did not affect public health, safety or morals).

B. *The Right to Refuse Treatment has Never been Equated with Suicide by an Appeals Court or State Legislature and is Unrelated to any Purported Right to Physician Assisted Suicide.*

Both the Ninth and Second Circuit Courts of Appeals base their opinions on the finding that there is no difference between the act of refusing life-sustaining treatment and suicide. In this they are both wrong. Nonetheless, even though courts have repeatedly found that refusing treatment is not suicide, there is some language in two judicial opinions that show a confusion between refusing treatment and suicide. In *Georgetown College*, the judge states, with no analysis,

> where attempted suicide is illegal by the common law or statute, a person may not be allowed to refuse necessary medical assistance when death is likely to ensue without it. Only quibbles about the distinction between misfeasance and nonfeasance, or the specific intent necessary to be guilty of attempted suicide, could be raised against this latter conclusion.

331 F.2d at 1008-9.

This statement is startlingly incorrect. First, at the time it was made, neither the common law nor statutes made it a crime to attempt to commit suicide. Second, the distinction between misfeasance and nonfeasance is far from a quibble. Third, the issue of specific intent is a critical element to be guilty of a crime. Fourth, the judge recognized that the patient did not want to die, but rather death would be "an unwanted side effect of a religious scruple." 331 F.2d at 1009. Finally, the judge found that the patient was incompetent. Because she was not capable of making any decision, she could not attempt to commit suicide. Thus, the discussion of attempted suicide is both misinformed and irrelevant given the facts of the case.

The second case that confuses treatment refusal and suicide is strikingly similar in its lack of analysis. In *JFK Memorial*

Hospital v. *Heston*, 58 N.J. 576, 279 A.2d 670 (1971), the New Jersey Supreme Court ordered a blood transfusion for a 22-year-old Jehovah's Witness who was injured in an accident. In its decision the court said, "It seems correct to say there is no constitutional right to choose to die. Attempted suicide was a crime at common law and was held to be a crime [in New Jersey]. It is now denounced as a disorderly persons offense." 58 N.J. at 580, 279 A.2d at 672. Once again there was no analysis, merely an assumption that refusing treatment was the same as attempting suicide. Again the person in question was unconscious and therefore could not attempt suicide.

The courts that have actually analyzed this issue have readily distinguished refusing treatment from suicide. The same court that decided *Heston* later decided *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). In that case, referring to *Heston*, the New Jersey Supreme Court wrote, "we would see, however, a real distinction between the self infliction of deadly harm and a self determination against artificial life support or radical surgery. . . ." 70 N.J. at 43, 355 A.2d at 665.

In a later case the New Jersey Supreme Court addressed the issue more directly, saying:

> declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. . . . The difference is between self-infliction or self-destruction and self-determination. To the extent that our decision in *[Heston]* implies the contrary, we now overrule it.

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985).

All the courts that have enforced the right to refuse treatment have pointed out that the state may have compelling

interests that would allow it to abridge the exercise of that right. One of the avowed countervailing state interests is the prevention of suicide.[4] However no court has ever prevented a person from refusing treatment on the grounds that it would constitute suicide. Rather, *all* courts since *Quinlan* that have considered the issue distinguish between refusing treatment and attempting suicide. *See, e.g., Superintendent of Belchertown* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). ("There is no connection between the conduct here at issue [refusing life-saving treatment] and any state concern to prevent suicide"); *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 4th Dist. 1978) (removing respirator from competent person would not be suicide but rather death from natural causes); *Bartling* v. *Superior Court*, 163 Cal. App.3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984); *Matter of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act").

[4] The other articulated state interests are the preservation of life, the protection of innocent third parties and the protection of the ethical integrity of the medical profession. The state's interest in the preservation of life has not been used to deprive individuals of their right to refuse treatment. Neither has the interest in the integrity of the medical profession been used this way. It had been thought that the interest in the protection of innocent third parties might cause courts to restrict the exercise of this right when the person refusing life saving treatment was the parent of a minor child. It has not been used this way, and courts have upheld the right of people with children to refuse treatment. *e.g, Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990); *Norwood Hospital* v. *Munoz*, 409 Mass. 116, 564 N.E.2d 1017 (1991). This interest has been mistakenly used to attempt to prospectively restrict a treatment refusal of a woman during childbirth by one state supreme court. *Jefferson* v. *Griffin Spalding Co. Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457 (1981). A more recent case has properly repudiated the use of force during childbirth as entirely unprincipled. *In re A. C.*, 573 A.2d 1235 (D.C. App. 1990). George J. Annas, Standard of Care 35-46 (1993). Given the regularity with which courts cite these state interests, it is notable that they have not been exercised in practice to limit the right to refuse treatment.

This makes sense when one considers the legal elements of suicide. To commit suicide one must (1) have the specific intent to die, and (2) intentionally set the death producing agent into motion. *Saikewicz*, 370 N.E.2d at 426, n.11. In all the refusing treatment cases the person refusing the treatment did not put the death producing agent into effect; death would be caused by the underlying medical condition which the person did not cause. *None* of the courts that have decided the right to refuse treatment cases have questioned the state's interest in the prevention of suicide. Rather, they all distinguish suicide from treatment refusal. The fact that a treatment refusal leads to death does not mean the patient's refusal of treatment is suicide.[5]

[5] The parties in the right to refuse treatment cases also understood the difference between refusing treatment and suicide. For example, Karen Ann Quinlan was a young woman in a persistent vegetative state, but not terminally ill. Her parents demanded that their daughter's ventilator be discontinued because they believed that is what she would have wanted. The doctors refused. The New Jersey Supreme Court, the country's first to decide a case involving withdrawal of life-sustaining medical technology (sometimes mistakenly called a "right to die" case) agreed that her wishes should be respected, and the ventilator was removed. Neither Ms. Quinlan nor her parents on her behalf, all devout Catholics, ever thought they were involved in suicide. The New Jersey Supreme Court carefully reviewed Catholic doctrine, which adamantly opposes suicide, assisted suicide, and euthanasia, but supports the right to refuse treatment. Pope Pius XII, in his Nov. 24, 1957 *allocutio*, said "that withdrawal or nonuse of mechanical ventilation . . . is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life; and we must apply in this case the principle of double effect." 70 N.J. at 31, 355 A.2d at 658. *See also* Amicus Curiae Brief of the Medical Society of New Jersey.

Similarly, in a New York case, Brother Joseph Fox, an elderly Catholic brother of the Society of Mary, said to his friend and confessor Father Philip Eichner, before surgery, words to the effect, "If I wind up like Karen Quinlan, pull the plug." *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S. 2d 266 (1981). Since suicide is a mortal sin in the Catholic Church, it is likely that Brother Fox would have been horrified at the notion that his refusal of a ventilator when in a persistent vegetative state (the condition he actually was in after unsuccessful surgery) constituted suicide. Ethics and theology, like the law, recognize the difference between refusing treatment and suicide.

The Second Circuit Court of Appeals holding is based entirely on equal protection analysis, and thus its conclusion is controlled by its finding that there is not even the most minimally rational distinction between refusing treatment and suicide. The Second Circuit Court of Appeals opinion states,

> [I]t seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, *except for the previous attachment of life-sustaining equipment*, are not allowed to hasten death by self administering prescribed drugs.

80 F.3d at 728-9 (emphasis added).

This statement itself demonstrates that these classes of individuals are not similarly situated. One group is on life support, the other group is not. The fact that one group is on life support demonstrates that members of this group are being subjected to an ongoing bodily intrusion. This intrusion could only have taken place with their consent and, just as they could have refused the intrusion, they can withdraw their consent at any time. The circumstance that empowers the person on life-sustaining equipment to refuse further treatment is not the terminal illness, but the now undesired bodily intrusion. One need not be terminally ill to withdraw consent from an intrusion — one need only be intruded upon. Thus the "terminally ill" person *who is not on life support* is differently situated because he or she is not being subjected to an ongoing physical intrusion. Both have the same right to refuse treatment, although, as a practical matter, this right can only be exercised by one who is being treated or for whom treatment is recommended. In terms of the purported right to physician assisted suicide, the person on life support is treated identically to the person not on life support by the law: neither may have their suicide assisted by the provision of a prescription drug by their physicians (assuming that such an act by the physician is illegal at all).[6]

[6] It should be noted that no case has ever held that a physician who prescribes drugs a patient later uses to commit suicide is guilty of assisting suicide. No physician has ever been charged with such an offense. It is surprising that the Ninth Circuit Court of Appeals could simultaneously find that the doctors in Washington run a "severe risk of prosecution," 79 F.3d at 795, and that there is "no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." 79 F.3d at 811. In its footnote 54, it describes two cases where physicians were charged with directly administering lethal injections to patients. While the court refers to these as assisted suicide cases, they were in fact homicide cases. Both physicians were acquitted.

It is unlikely that the mere prescription of drugs for a patient constitutes assisted suicide. The named plaintiff in the Second Circuit Court of Appeals case, Dr. Timothy Quill, admitted in an article published in a prestigious medical journal that he had prescribed a lethal dose of sleeping pills for a patient so she could decide at some future time whether or not to commit suicide with these pills. Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691 (1991). Based on this admission, a Grand Jury investigated the case and refused to indict. Furthermore, the New York Board for Professional Medical Conduct conducted an investigation to determine if Dr. Quill should be disciplined for his actions. The panel found Dr. Quill acted lawfully and appropriately. It noted that he could not determine with certainty what use the patient might make of the drugs he prescribed. Even if Dr. Quill prescribed the drugs believing they might be used by the patient to commit suicide, he did not participate in the taking of her life. The panel did not wish to interfere with the good medical practice of physicians who prescribe drugs to relieve a terminal patient's anxiety, insomnia or pain because the physician suspects the patient may later use the medication to terminate his or her life. *See*, John Alesandro, Comment, *Physician Assisted Suicide and New York Law*, 57 Alb. L. Rev. 820, 823 n. 19 and 21 (1994). Thus, in the only case ever investigated that resembles the activities the plaintiffs claim are illegal in New York, the authorities ruled that the actions were lawful.

It must be kept in mind that the activity in question is the prescription of drugs by physicians. Once the prescription is written the patient must decide whether to fill it, and then must decide whether to use the drugs for the lawful purpose for which a prescription is written, such as relief of insomnia, or to take these drugs to commit suicide. These decisions all occur over a lengthy period of time. Thus there is a long and tenuous chain of events between the writing of the prescription and its use for suicidal purposes.

This is quite different from prosecuted assisted suicide cases, where there is a close link between the assistance and the act of suicide. In one case a defendant helped her sister to commit suicide by attaching a vacuum

Both the Second and the Ninth Circuit Courts of Appeals rely heavily on the termination of artificial nutrition and hydration cases to support the proposition that there is no difference between a physician who complies with a patient's right to refuse treatment and a physician who assists suicide. 79 F.3d at 822-823, 80 F.3d at 729. They argue that a person like Nancy Cruzan does not die of her underlying condition but rather of an independent cause, starvation. This is simply incorrect. When a person requires the administration of artifi-

cleaner hose to the end of an exhaust pipe of a car, gave her sister the other end of the hose, said good-bye and closed the garage door as she left. In another case a husband helped his cancer ridden wife commit suicide by preparing an overdose of sedatives, sitting with her while she ate it, and helping her put a plastic bag over her head. Catherine Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 366, n. 77, 79 (1986). In these cases, and others cited in the article, the "assistance" that was found to be unlawful was much more direct than writing prescriptions, much closer in time to the commission of the suicide, and led directly to the suicide. At least three of the six patient-petitioners in these two appeals were not suicidal at the time they signed their declarations, but rather wanted exemptions from the drug laws so that they could have their physicians write them prescriptions for lethal drugs that they *might* use at some time in the future to commit suicide *if* their suffering became intolerable. 79 F.3d 794-5; 80 F.3d 720-21.

It is notable, given the relief sought in this case by the plaintiffs, that no court has actually concluded that writing a prescription constitutes assisting suicide. Perhaps the federal courts should have remanded the issue to the state courts for a definitive interpretation of the statutes in question. Both statutes are written in general terms and neither explicitly forbids physicians from writing prescriptions for their patients. Furthermore, it may have been possible for the federal courts to have interpreted the statutes in a way that would have made it unnecessary for them to decide the constitutional question. *Communications Workers of America* v. *Beck*, 487 U.S. 735, 762 (1988).

Interestingly, the Ninth Circuit opinion states "we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as 'suicide'." This is likely to be correct, and if it is correct then there is no need to resolve whether there is a constitutional right to assistance. If writing a prescription for drugs a patient may or may not use at some unspecified future time to commit suicide does not constitute assisted suicide under state law, then physicians may prescribe such drugs for their terminally ill patients without any constitutional determination by a federal court.

cial forms of nutrition and hydration for his continued existence, this is beacuse, by definition, he suffers from a condition that prevents him from eating and drinking in a normal fashion. In the absence of medical treatment that provides artifical nutrition and hydration, the person would die from the lack of nutrition or hydration which is itself caused by the disease or condition. Thus, terminating artifical nutrition or hydration is no different from terminating any other medical treatment including artifical respiration, kidney dialysis or chemotherapy.[7] Termination of treatment returns the person to the status quo prior to the bodily intrusion. Subsequently, in the absence of these intrusions, the disease takes its course.

This is in stark contrast to assisted suicide. In such a case the person dies from a cause entirely external to the disease or condition from which the person suffers. If a person has cancer or AIDS, the person will not die from a barbiturate overdose, potassium chloride poisoning, or carbon monoxide poisoning unless these foreign substances are introduced into the person's body. If the substances are introduced, then death would be caused by poisoning, and not by the disease process taking its course.

The failure to distinguish real causes of death from the medical tools and techniques that may temporarily substitute for particular bodily functions is fatal to the logic of both of these opinions. If one were to accept that Nancy Cruzan "died of

[7] "Artifical feeding cannot be distinguished from other forms of medical treatment ... the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artifical delivery of food and water." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 288-289 (1990) (O'Connor, J., concurring); "artifical feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding — thay are medical porcedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning," *In re Conroy*, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985).

starvation" and not from the vegetative condition that made it impossible for her to eat or drink, one would also have to accept the conclusion that when physicians stop attempted cardiopulmonary resuscitation on a patient in cardiac arrest, what kills the patient is not the cardiac arrest but rather the physician who intentionally stops compressing the heart. Since the failure to perform cardiopulmonary resuscitation always "hastens death," under each court's logic, patients who refuse cardiopulmonary resuscitation would always be committing suicide.

Similarly, the Ninth Circuit Court of Appeals wrongly assumes that physicians who administer drugs for pain relief that could also shorten life *intend* the death of the patients. 79 F.3d at 827. This indicates that the Ninth Circuit Court of Appeals misunderstands the principle of the double effect, in which an action may have two known consequences, only one of which is intended. Thus, the conclusion that pain relief and death are equally intended by a physician who administers a pain-relieving drug that may also shorten life is false. Physicians titrate pain relieving drugs in an attempt to provide maximum effective pain relief without causing death. The principle of the double effect means that treating the patient's pain is acceptable even if the treatment may hasten death. Providing medication to control pain has always been a legitimate and lawful medical act, even if death or suicide is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.[8] The difference between

[8] As one of the dissenting judges, Andrew Kleinfeld, in the Ninth Circuit Court of Appeals opinion, properly notes, when General Dwight D. Eisenhower ordered American troops to the beaches in Normandy, he knew he was sending many to certain death, but his purpose was to liberate Europe from the Nazis. Judge Kleinfeld continued, "The majority's theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers." 79 F.3d at 858 (Kleinfeld, J., dissenting).

intended and unintended but foreseen consequences of medical treatment was also addressed by the first presidential bioethics commission. It concluded that the relevant moral issue:

> . . . is not really that death is forbidden as a means to relieve suffering but is sometimes acceptable if it is merely a foreseeable consequence. Rather, the moral issue is whether or not the decisionmakers have considered the full range of foreseeable effects, have knowingly accepted whatever risk of death is entailed, and have found the risk to be justified in light of the paucity and undesirability of other options.

PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 82 (1983).

There are other important differences between assisted suicide and refusing treatment. Unlike assisted suicide there are currently no statutes, and there have never been any statutes, that prohibit a person from refusing treatment. Nor have any statutes been necessary to grant individuals the right to refuse treatment.[9] The case law that exists in this area did not come about as a result of individuals attempting to invalidate state law. Rather the case law was developed because individuals were being denied their right to refuse treatment by other individuals, or because someone brought an action in an

[9] All states have adopted "Natural Death Statutes," "living will" laws, health care proxy laws, durable power of attorney laws or similarly entitled statutes. These are all for the purpose of enabling decisionmaking on behalf of *incompetent* persons. They have no relevance to the issue of a competent person's right to make health care decisions for him- or herself except as they extend this right into the state of incompetence.

attempt to force treatment on an unwilling person. Thus, unlike the assisted suicide cases before the Court, the courts have not been asked to invalidate legislative judgments in the refusing treatment cases. Even in *Cruzan*, this Court was not asked to rule on a statute, but on a burden of proof standard that was created by a state supreme court. Moreover, neither the Missouri Supreme Court nor this Court even raised the question of whether withdrawing Nancy Cruzan's feeding tube based on her wishes would violate Missouri's law against physician assisted suicide. The relevance of this to the instant case is to note that legislatures across the county have prohibited assisted suicide but have never prohibited competent persons from refusing treatment. This in and of itself is strong evidence of the difference between treatment refusal and suicide.

The right to refuse treatment is an expression of the patient's autonomy and the right to refuse unwanted bodily invasions. Any competent adult can refuse treatment for any reason. The right of a competent person to refuse treatment has never been conditioned on having a terminal illness or any other medical status. Nor does a patient need the permission or cooperation of a physician to refuse treatment. If a person refuses treatment, the physician may not lawfully treat the person. If the patient withdraws consent to treatment, the physician must cease to treat the person.

In contrast, the purported "right" to physician assisted suicide in the instant cases is defined entirely by a physician's subjective assessment of the patient's circumstances. The person must be found to be "terminally ill" (an undefined and undefinable term), must be in a condition where death will soon occur, and must be suffering in a way a physician finds distressing enough to prescribe the desired drugs. This is unrelated to the right of all individuals to refuse treatment for their own reasons. This Court should affirm the right to refuse treatment and make clear that rejection of the purported right to assisted suicide does not in any way undermine the right to refuse treatment.

II. The Constitutional Right Of Pregnant Women To Terminate A Pregnancy Is Based On Facts And Constitutional Principles That Do Not Encompass Any Asserted Constitutional Right To Physician Assistance In Suicide.

A. *The Constitutional Right of a Pregnant Woman to Terminate her Pregnancy is Based on her Interest in her own Life, Health, and Future.*

The Ninth Circuit Court of Appeals saw no difference between the woman's interest in continuing or terminating a pregnancy, and a terminally ill person's interest in obtaining assistance in committing suicide, finding both "central to personal dignity and autonomy." 79 F.3d at 813-814. But this parallel could be drawn only by misunderstanding the fundamental basis on which the abortion cases have been decided. Constitutional protection of a woman's right does not require also protecting a right to physician assisted suicide.

The Ninth Circuit Court of Appeals reached its conclusion that there is a substantive due process right to determine "the time and manner of death" almost solely on the basis of the following two sentences from the joint opinion in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992).

> "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

79 F.3d at 813.

Unlike the Ninth Circuit, however, the joint opinion in *Casey* continued its reasoning after the two sentences quoted above, saying, "These considerations begin our analysis ... but cannot end it. ..." 505 U.S. at 852. In *Casey*, as in earlier decisions, this Court recognized a constitutional right related

to "marriage, procreation, contraception, family relationships, child rearing, and education." 505 U.S. at 851. In *Casey*, the Court reaffirmed "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child." 505 U.S. at 851. This choice is so central to a woman's life, health, future, and place in society that only she should be able to make it. This is because, as the joint opinion in *Casey* explained, "abortion is a unique act ... [T]he liberty of a woman is at stake in a sense unique to the human condition and so unique to the law ... The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." 505 U.S. at 852.

The reasons for protecting a woman's right to choose to continue or terminate a pregnancy simply do not apply beyond pregnant women. A woman's decision whether to have a child determines not only her future relationships with others but her own conception of herself and her role in society. Furthermore, the constitution protects the woman's right in order to ensure that women are treated fairly as free and equal participants in a democracy. ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." 505 U.S. at 856). The woman's right is thus "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937).

None of these reasons apply to a person who seeks assistance in committing suicide. A decision to commit suicide does not further the goals of reproductive liberty, equality and full participation in the "economic and social life of the nation," values preserved by the Court in *Casey*. Therefore, the Second Circuit Court of Appeals was correct to reject a substantive due process right to assistance in suicide based on the abortion cases. 80 F.3d at 725.

B. *Unlike Other Aspects of Personal Life That Have Been Protected From State Interference by the Constitutional Right of Privacy or Personal Liberty, the Right to Physician Assisted Suicide Is Poorly Defined and Its Exercise Cannot be Limited by Logic or Principle.*

The very core of the constitutional privacy and liberty cases is that individuals have "zones of privacy" into which the government may not enter. These involve decisions that are so personal and important to the individual, and which do not affect the general public, that government simply has no role in limiting the decisions an individual might make in these areas. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), *Carey* v. *Population Services*, 431 U.S. 678 (1977). *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972). In *Griswold*, by outlawing the use of contraceptives, the state required married people to risk pregnancy or to refrain from marital sexual relations. *Griswold* forbade the state from invading the marital bedroom and controlling the activities that occurred there. In *Eisenstadt* and *Population Services*, the Court extended *Griswold* by properly noting that the decision whether or not to bear or beget a child is a *personal* right that is reserved to every person, and that the state has no role in that highly personal decision. Likewise, in *Roe* v. *Wade*, 410 U.S. 113 (1973), and its progeny, including *Casey*, the Court has continued to recognize this zone of privacy into which the state could not intrude.

What is notable about this line of cases, and the cases which supplied the conceptual foundation for them, *Loving* v. *Virginia*, 388 U.S. 1 (1967), *Stanley* v. *Georgia*, 394 U.S. 567 (1969) and *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), is that they involved discrete decisions, made by members of a readily identifiable category of individuals, who did not have to justify the reasons for their decisions.

Prior to *Roe*, there were states that permitted a woman to terminate pregnancy if she had a reason the state found

acceptable. Some states permitted a woman to terminate her pregnancy if it endangered her life; others if it endangered her health. Still other states allowed termination of pregnancy if the woman was impregnated as a result of rape or incest, or if the fetus was malformed enough to satisfy the state. The essential underpinning of *Roe* is that it is not for the state to determine whether a woman's reason for terminating her pregnancy is legitimate; rather only the woman herself can make this very private, personal and life changing decision. Because the reasons are so personal, she need not give a reason. This is also true of other decisions that this Court has recognized are protected by the constitutional rights of personal privacy and liberty. Thus, no one needs to justify to the state their reasons for wishing to use contraceptives, or to send their child to a parochial school, or to marry a person of a different race.

In a similar respect, it is clear who comes under the protective umbrella of the right of privacy or personal liberty as applied by this Court. *Every* pregnant woman may choose whether or not to terminate her pregnancy; *every* person who engages in sexual activity may choose whether or not to use contraceptives; *every* parent may choose what type of school their child attends; *every* person may decide whom to marry regardless of race.

In its conclusion, the Ninth Circuit Court of Appeals says, "We hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." 79 F.3d at 838. In stark contrast to contraception, abortion and marriage rights, the scope of the right to assisted suicide as portrayed by the Ninth Circuit Court of Appeals is not ascertainable.

Moreover, unlike the broad classes of people to whom other liberty rights apply, the "right" to suicide assistance described

by Ninth Circuit Court of Appeals only applies to "terminally ill" people. Unlike pregnant women, for example, this is not an objectively definable class. Arguably, anyone who is diagnosed with an incurable, lethal disease is terminally ill. Thus, an AIDS patient with a life expectancy of five years, an 18-year-old with cystic fibrosis and a twelve year life expectancy and a cancer patient who is in the final stages of a disease, are all "terminally ill." In some places the Ninth Circuit Court of Appeals describes a terminally ill patient as one who has an "incurable and painful degenerative disease" that leads to "debilitating pain and humiliating death." 79 F.3d at 821. Elsewhere the court describes patients "wracked by pain and deprived of all pleasure." 79 F.3d at 814. Still elsewhere the court argues that a person who is "reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent," has "a strong liberty interest in choosing a dignified and humane death." 79 F.3d at 814. Obviously these are people who are suffering from different conditions.

The Ninth Circuit Court of Appeals itself acknowledges that the term "terminally ill" does not constitute a "clear line of demarcation." 79 F.3d at 830. But the court draws comfort from the fact that some states in their "natural death laws" have defined terminal illness as meaning death is likely to ensue in six months. It is remarkable that the Ninth Circuit Court of Appeals creates a constitutional right for a class it cannot define in any principled way because some state legislatures have adopted an arbitrary definition (and one that applies to differently-situated people for different reasons). This is a dramatic departure from the thoughtful and precise way this Court has applied the constitutional right of privacy or liberty in other contexts.

The Ninth Circuit Court of Appeals also seems to believe that, unlike the exercise of other rights in this area, it can require people to justify their individual exercise of this right. Thus the court imperiously asserts that a forty-year-old alcoholic has no right to physician assisted suicide but does not explain why his suffering does not entitle him to the rights

the court grants other suffering patients. 79 F.3d at 821. Assume that this person has struggled with his alcoholism for 20 years, has lost his job and family as a result of his drinking, and has repeatedly undergone unsuccessful treatment. Why does the court think that *it* or the *state* can determine that this person's very real, ongoing and life long suffering and humiliation do not meet the constitutional requirements for assisted suicide, but that a cancer patient's suffering at the end of life does? No constitutional principle can distinguish these two cases.

This is not a "slippery slope" argument. The point is that if assisted suicide is a constitutionally protected right to end suffering, then neither the courts nor the states should be able to say how much suffering is enough. That is necessarily a personal judgment to be made by the individual. The very failure of the Ninth Circuit Court of Appeals to recognize this point demonstrates that the "right" to assisted suicide is not like the right to choose to terminate pregnancy or the right to use contraception, and thus is not related to the privacy and liberty rights this Court has previously recognized.

C. *Any Purported Constitutional Right to Physician Assistance in Suicide does not Follow from a Woman's Right to Terminate a Pregnancy because (1) Assistance in Suicide is not a Medical Procedure; and (2) Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.*

1. *Assistance in Suicide is not a Medical Proedure.*

Abortion is and has always been a medical procedure, and thus only licensed physicians may lawfully perform abortions. *Roe* described "the abortion decision in all its aspects" as "inherently and primarily a medical decision." 410 U.S. at 165. Unlike abortion, assisting a suicide requires no special

medical skills or knowledge. Assisting patients to commit suicide is not taught in medical schools, tested on any medical board examinations or discussed in the standard medical texts. Self-abortions and abortions done by nonphysicians are dangerous to women's lives and health. The safety of suicide is not an issue. Almost all competent adults are capable of successfully committing suicide, and tens of thousands do so every year in the United States. Assisting suicide is not a medical procedure, and medicalizing an act runs the risk of making an otherwise unacceptable act appear acceptable. The country's most notorious practitioner of assisted suicide, Jack Kevorkian, uses carbon monoxide poisoning, a method that is entirely nonmedical in nature. George J. Annas, *Physician Assisted Suicide — Michigan's Temporary Solution*, 20 Ohio N. U. L. Rev. 561, 568 (1994). Although Kevorkian's medical license has been revoked, no one has ever argued that he should be prosecuted for the unlawful practice of medicine. This is because assisted suicide is not the practice of medicine, and does not require any medical knowledge or access to any medical drugs or devices. The Ninth Circuit Court of Appeals itself recognized that physicians need not be involved in the final act of assisted suicide by extending immunity to cover family members and other nonphysicians. 79 F.3d at 839. This is why, unlike laws against abortion, laws against physician assisted suicide do not have a unique impact on physicians.

The Ninth Circuit Court of Appeals could not explain why the constitutional right to assisted suicide, a right that purportedly belongs to the "terminally ill" person, can or should be limited to assistance by physicians, or to one particular suicide assistance technique, namely prescribing drugs. Unlike abortion, suicide can be accomplished in many nonmedical ways. If there is a right to commit suicide with prescription drugs, then there must also be a right to commit suicide using a gun, if that is what the terminally ill patient so desires. There is no principled way to distinguish between methods of suicide, and it is impossible to create a constitutional right to commit suicide using one means but not another. Indeed,

it is likely, given the lack of training physicians receive in this area, that a person could receive more effective assistance in suicide from an executioner than from a physician.

In 1989, a similar Amicus group of bioethics professors argued to the Court that the constitutional right of privacy protects a woman's right to make the personal medical decision whether to terminate a pregnancy in the privacy of the physician-patient relationship, free from state intrusion. Brief for Bioethicists for Privacy as Amicus Curiae Supporting Appellees in *Webster* v. *Reproductive Health Services*, No. 88-605 (reprinted in the Joint Appendix accompanying *Washington* v. *Glucksberg*, No. 96-110, at 95-127). Amicus believes that the arguments made there remain valid. Nonetheless, accepting them does not require the Court to protect any right to assisted suicide because the decision to commit suicide or to request assistance in suicide is not a personal *medical* decision, and because assisted suicide is not a *medical* procedure.

Assisted suicide is not like abortion. In abortion, the Court protected an activity that necessarily occurred in the confines of the private physician-patient relationship. In assisted suicide, neither physicians nor medical procedures are necessary. Thus, unlike abortion, limiting the right of assisted suicide to aid by physicians is illogical, arbitrary, and not derived from any constitutional principle.

2. ***Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.***

Abortion is performed in the context of a confidential physician-patient relationship without direct state or third party interference or review. Protection of the right to decide whether to terminate a pregnancy requires keeping the states out of this confidential relationship. In contrast, all proposals to "legalize" physician assisted suicide require or encourage

intrusions into the physician-patient relationship by mandating outside review and approval of the patient's decision. Daniel Callahan & Margot White, ***The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village***, 30 U. RICHMOND L. REV. 1, 8-9 (1996). Both Circuit courts called on states to regulate physician assisted suicide to prevent abuses, and the Ninth Circuit Court of Appeals seemed to endorse Oregon's law, the only existing state law on the subject in the U.S. Or. Rev. Stat. §127.800 et seq. (1995).

The Oregon law grants legal immunity for physicians who prescribe lethal medications for their competent terminally ill patients (defined as those with 6 months or less to live) who express a desire to use these drugs to commit suicide. However, prior to writing the prescription, the physician must obtain a request for the prescription, in writing and signed in the presence of at least two witnesses who certify that the patient is competent and acting voluntarily. In addition, at least two physicians must agree that the patient is likely to die from a terminal illness within six months and the patient must be referred for psychiatric or psychological counseling. Finally, waiting periods are built in: two oral requests are required, the second no less than 15 days after the original oral request, and the prescription itself cannot be provided less than 48 hours after the written request. Under *Doe* v. *Bolton*, 410 U.S. 179 (1973), this burdensome and intrusive procedure would not be constitutionally permissible if the right to physician assisted suicide is based on a fundamental liberty interest; in abortion no one gets to second guess the woman's constitutionally-protected decision.

Unlike abortion, physician assisted suicide is recognized, even by the two Circuit Courts of Appeals that have asserted that it is a constitutional right, as far too dangerous a right to be exercised by patients and physicians alone.

The conclusion is inescapable: the woman's right to make decisions regarding abortion is unique, and unlike assisted suicide, protects the life, health, and future well being of women.

CONCLUSION

Amicus therefore respectfully requests this Court to:
1) Reverse the judgment of the Ninth Circuit Court of Appeals,
2) Reverse the judgment of the Second Circuit Court of Appeals,
3) Explicitly recognize that rejection of a constitutional right to physician assistance in committing suicide in no way affects the common law and constitutional right to refuse medical treatment,
4) Explicitly recognize that rejection of a right to physician assistance in committing suicide in no way affects a woman's constitutional right to determine whether or not to terminate her pregnancy.

Respectfully submitted,

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Nos. 96-110 & 95-1858

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, ET AL., *Petitioners*,

v.

HAROLD GLUCKSBERG, ET AL., *Respondents*.

&

DENNIS C. VACCO, ET AL., *Petitioners*,

v.

TIMOTHY E. QUILL, ET AL., *Respondents*.

On Writs of Certiorari to the United States Court of Appeals
for the Ninth & Second Circuits

BRIEF AMICI CURIAE OF GARY LEE, M.D., WILLIAM PETTY, M.D., FRITZ BECK, JUNE BECK, WILLOWS RESIDENTIAL CARE FACILITY, SISTER GERALDINE BERNARDS, MARYVILLE NURSING HOME, INC., JANICE ELSNER, CLAUDINE STOTLER, JEFFREY M. WEINKAUF, AND PHYSICIANS FOR COMPASSIONATE CARE IN SUPPORT OF PETITIONERS

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38 pp

QUESTIONS DEALT WITH HEREIN

1. Whether safeguards will protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized.

2. Whether safeguards will be repeatedly challenged and frequently struck down.

3. Whether the recognition of a constitutional right to assisted suicide will be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

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INTEREST OF AMICI CURIAE[1]

With one exception, the amici curiae are the plaintiffs who successfully challenged Oregon Ballot Measure 16 which legalized physician-assisted suicide in the state of Oregon. *Lee v. State of Oregon*, 891 F. Supp. 1421 (D.Or. 1995). That case is currently on appeal before the U.S. Court of Appeals for the 9th Circuit. A decision in this case recognizing a constitutional right to physician-assisted suicide would negatively impact their case on appeal. The *Lee* plaintiffs oppose any recognition of a constitutional right to assisted suicide because vulnerable persons cannot be adequately protected from undue influence, duress, and the affects of depression.

Gary Lee, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Eugene, Oregon. All of his patients are cancer patients, many of whom will die with advanced cancer. Many of these patients suffer from depression; however, physicians are not well-trained in diagnosing depression so this problem is generally undertreated. Depression makes patients who have the disability of a terminal disease highly susceptible to undue influence in the form of suggestions that their lives are not worth living. He asserts the interests of his patients who have the disability of a terminal disease who do not wish to engage in assisted suicide but may be subject to internal and external pressures toward assisted suicide which they may be unable to resist given the lack of appropriate safeguards.

William Petty, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Portland, Oregon. Eighty percent of his patients are cancer patients, and many will die as a result of their disease. He observes that these patients are especially susceptible to undue influence because they become vulnerable and compliant. He asserts the interests of his patients who have the disability of a terminal disease.

Janet Elsner is a person with progressive muscular dystrophy who uses a wheelchair. She is 46 years old and is a resident of Portland, Oregon. Ms. Elsner has had periods where she is so weak that she is limited to a liquid diet because she is too tired to

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[1]Consents from the parties to filing this brief have been filed with the Clerk.

eat. At such times, she cannot even turn over in bed. She does not know how long she has to live and has already lived longer than expected. She has problems with depression as a result of her illness and understands that depression may go undiagnosed and cause persons to consider suicide. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Claudine Stotler is a resident of Washington County, Oregon, who has been diagnosed by her physician with cancer from which she will die. Ms. Stotler would never want to consider assisted suicide but understands that persons who have the disability of a terminal disease are sometimes subject to undiagnosed depression or undue influence while in a debilitated state and become persuaded to act contrary to their true intent, which she would never want to happen to her. She has been subject to depression at times since being diagnosed with cancer. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Jeffrey M. Weinkauf is an insulin-dependent individual with diabetes, who is a resident of Eugene, Oregon. Oregon Ballot Measure 16 defines "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." Under this definition, Mr. Weinkauf's diabetes might constitute a terminal disease because it is an incurable and irreversible disease and, without insulin treatment, he will die within six months. The statute thus does not differentiate between diseases which are controllable with regular medication and those which are not. He joins this brief in his own behalf and as a representative of those persons who have a possibly terminal disease absent medical treatment.

Fritz and June Beck are residents of Bandon, Oregon, and are owners of The Willows Residential Care Facility, located in Bandon. Sister Geraldine Bernards is an Oregon resident and the Administrator of the Maryville Nursing Home, Inc., located in Beaverton, Oregon. These nursing homes house persons who have the disability of a terminal disease. If assisted suicide is legalized,

they would be required to permit the assisted suicide of a patient who has the disability of a terminal illness in their facility under Oregon Ballot Measure 16. Furthermore, they would be required to appoint a witness to witness any written consents to assisted suicide and would be prohibited from excluding physicians who wish to commit assisted suicide on their premises from prescribing lethal drugs to qualified residents of their facility. Because of their strong religious opposition to such practice, they believe they would have their free exercise of religion violated, contrary to the guarantees of the First Amendment and the Religious Freedom Restoration Act. In addition, they believe their First Amendment right to freedom of association would be violated if they were forced to allow assisted suicide to occur in their facility.

Physicians for Compassionate Care (PCC) is an Oregon nonprofit corporation with membership open to physicians, nurses, and other health care professionals. Its membership consists of over 500 health care professionals. Its purpose is to promote compassionate care for severely ill patients without sanctioning or assisting their suicide. Members affirm an ethic based on the principle that all human life is inherently valuable and that the physician's roles are to heal illness, alleviate suffering, and prolong life. Most of the organization's members treat patients who are terminally ill. It was not a plaintiff in the *Lee v. Oregon* case.

SUMMARY OF THE ARGUMENT

What this Court is being asked to do is to recognize a right to assisted suicide (by lethal dose of drugs) for competent people which will invalidate all state laws prohibiting assisted suicide. This brief will present three public policy reasons why such a constitutional right should not be recognized.

First, the decision of the 9th Circuit assumes that "sufficient safeguards can and will be developed by the state and medical profession." However, there are no safeguards that will be sufficient to protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized. This can be seen by an analysis of the safeguards in Oregon Ballot Measure 16, which became law in

November 1994, but was enjoined prior to its effective date by the U.S. District Court. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized. However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death. For these reasons, the typical safeguards being proposed today are inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

Second, any proposed safeguards will undoubtedly be challenged and frequently struck down. This can be seen from the abortion litigation of the past twenty-five years. The 9th Circuit recognized this fact when it stated: "In deciding 'right-to-die' cases, we are guided by th[is] Court's approach to the abortion cases." Because abortion safeguards have been repeatedly challenged and frequently struck down in the past, we can expect the same result regarding any proposed assisted suicide safeguards. Therefore, if this court recognizes a new constitutional right to assisted suicide, the abortion precedents will control and will result in the striking down of many if not most safeguards. Physician-assisted suicide will be uncontrollable.

Third, the recognition of a constitutional right to assisted suicide will not be limited to persons who are terminally ill and mentally competent. The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will

permit assisted suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit recognized this when it specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. Similarly, if a right to assisted suicide is recognized, equal protection clause jurisprudence will require the recognition of a right to euthanasia (by lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights without assistance. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

For these public policy reasons this Court should hold that there is no right to assisted suicide in the Constitution of the United States, and should find that the decisions of the Second and Ninth Circuits should be reversed and/or vacated.

ARGUMENT

I. Safeguards Will Not Protect Vulnerable Persons.

In *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), the 9th Circuit held that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." *Id.* at 838. It also stated that "we believe that sufficient safeguards can and will be developed by the state and medical profession to ensure that the possibility of error will ordinarily be remote." *Id.* at 824. When the medical facts are analyzed, it is clear that the safeguards envisioned by the court will not be sufficient to protect vulnerable persons. The 9th Circuit cites the procedural safeguards in Oregon's Ballot Measure 16 as "a good example of how these legitimate and important concerns [i.e., errors, abuses, and legitimate state interests] can be addressed effectively." *Id.* at 833 & n.122.

The State of Oregon is the first state to legalize physician-

assisted suicide. However, before the law went into effect, it was successfully challenged by the *amici* herein, who are the plaintiffs in the case of *Lee v. Oregon*, 891 F. Supp. 1421 (D. Or. 1995). The U.S. District Court issued preliminary and permanent injunctions. *Id.* at 1439 (permanent injunction); 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction). It is now on appeal before the U.S. Court of Appeals for the 9th Circuit. A right to assisted suicide, whether created by referendum, by statute, or by recognition of a new constitutional right, constitutes an exception to the plethora of state laws protecting vulnerable persons. For example, the following Oregon statutes protect its vulnerable citizens.

Oregon Revised Statutes § 163.117 provides that:

> It is a defense to a charge of murder that the defendant's conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude a conviction of, manslaughter or any other crime.

Oregon Revised Statutes § 163.125 provides that:

> (1) Criminal homicide constitutes manslaughter in the second degree when:
>
> (a) It is committed recklessly; or
>
> (b) A person intentionally causes or aids another person to commit suicide.
>
> (2) Manslaughter in the second degree is a Class B felony.

Oregon Revised Statutes § 161.205 provides that:

> The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances: . . . . (4) A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical self-injury may use physical force upon that person to the extent that the person reasonably believes it necessary to thwart the result.

Oregon Revised Statutes § 426.005 defines a "mentally ill person" as, inter alia, "a person who, because of a mental disorder is . . . [d]angerous to self . . . ." Oregon Revised Statutes

§ 426.070 et seq. provide commitment proceedings for one who is a "mentally ill person," including emergency commitment proceedings.

While the foregoing statutes protect most Oregon residents from self-harm and assisted suicide, Oregon has by Ballot Measure 16 determined that the lives of persons who have the disability of a terminal disease, who are suffering from depression or undue influence, are not entitled to the same protections from self-harm and assisted suicide as those not deemed terminally ill.

The following are the relevant provisions of Ballot Measure 16: (1) a written request by an adult who has been determined by two physicians to be suffering from a terminal disease; (2) two witnesses who attest that the patient is capable, acting voluntarily, and not under coercion; (3) the attending physician shall inform the patient of his diagnosis, prognosis, potential risks in taking a lethal medication, the probable result, and the feasible alternatives; (4) the consulting physician shall examine the patient and his records, confirm in writing the diagnosis, verify that the patient is capable and acting voluntarily; (5) if either physician thinks the patient may be suffering from a psychiatric or psychological disorder, or depression, he will refer the patient for counseling; (6) the attending physician shall ask the patient to notify the next of kin of his request for medication; (7) a fifteen day waiting period; (8) civil and criminal immunities for the physicians and health care providers. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized.[2]

However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly

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[2]These are the type of "appropriate, reasonable, and properly drawn safeguards" suggested by the 9th Circuit. Compassion in Dying v. State of Washington, 79 F.3d 790, 833 (listing example safeguards that could be adopted).

suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death.

First, physicians are unable to accurately diagnose a person as having a "terminal disease." The U.S. District Court in Oregon found that "physicians often misdiagnose terminal illness" and that "a physician's prognosis of six months to live is often fallible." *Lee v. State of Oregon*, 869 F. Supp. 1491, 1497. The *Affidavit of Richard Fenigsen, M.D., Ph.D.*[3] gives evidence of a 20-40% error rate even in the clinical diagnosis of a particular disease. *Fenigsen Affidavit* at ¶ 6. The Oregon defendants did not contest this fact. In one study, lung cancer was misdiagnosed in over 49% of the cases. *Id.* A report in the *British Medical Journal* of four patients referred to a hospice for terminal care with "untreatable cancer" revealed that they had neither terminal illness nor cancer. *Id.* at ¶ 7. "One of these patients had the [erroneous] diagnosis of cancer established (from pleural biopsy) by two pathologists and confirmed by a third." *Id.* Defendants did not contest these facts. As to the ability of a physician to predict that a patient will die of a disease within a certain amount of time, even if correctly diagnosed, that ability is "notoriously fallible." *Id.* at ¶ 17. Oregon defendants' *Affidavit of Timothy M. Quill, M.D.* (C.R. 84) appends an article by Dr. Quill in which he writes, "we acknowledge the inexactness of such prognostications [about whether a patient is

[3]Appellees' Supplemental Excerpts of Record 111 (hereinafter Supp. E.R.), Clerk's Record 33 (hereinafter C.R.), Lee v. Harcleroad, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949 (9th Cir., Jan. 24, 1996). Richard Fenigsen, M.D., Ph.D., has forty years of experience with severely ill and dying patients in the Netherlands. He has twenty years experience with euthanasia and physician-assisted suicide as practiced in hospitals and by family physicians in the Netherlands. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1497.

'near death']." *Id.* at Appendix D-2. According to the Michigan Supreme Court, "[n]o clear definition of 'terminal illness' is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die." *People v. Kevorkian*, 447 Mich. 436, 467 n.34, 527 N.E.2d 714, 726 n. 33 (1994). Thus, the purported safeguard of a "medically confirmed diagnosis carries a risk of error ranging from 20 to 40 percent." *Fenigsen Affidavit* at ¶ 8. Clearly, many "qualified patients" under Measure 16 will not actually be within six months of dying as Measure 16 envisions.

Second, people with terminal illness commonly suffer from the psychiatric illness of depression or another form of impaired judgment. The *Affidavit of Carol J. Gill, Ph.D.*[4] establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Receiving a diagnosis of a terminal disease is clearly a major life stress and personal loss. A pamphlet entitled *Depression: What You Need to Know*, published by the National Institute of Mental Health (no date), at 4, and placed in the *Lee v. Oregon* record as an attachment to the affidavit of Intervenor Levin (Exhibit 28 to Exhibits to Intervenor Levin's "Motions Against Plaintiffs' Claims"; C.R. 149), confirms Dr.

[4]Supp. E.R. 21, C.R. 29. Carol J. Gill, Ph.D., is a clinical psychologist specializing in issues affecting persons with disabilities, pain, and/or chronic illnesses. She has worked clinically with this population in both hospital settings and private practice. Her former positions include: Director of Rehabilitation Psychology at Glendale Adventist Medical Center, Commissioner in Psychology on the Los Angeles County Commission on Disability; and Acting Director of the Program in Disability and Society at the University of Southern California. For the past five years, she has devoted her professional life to research and education projects concerning persons with disabilities and chronic illness. She is currently the President of the Chicago Institute of Disability Research. Her affidavit was cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

Gill's assertion, stating that: "A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode." Thus, many people with the major life stress of a diagnosis of terminal illness will suffer from depression, whether or not it rises to the level of clinical or major depression, and will have impaired judgment for making life and death decisions, even though legally competent. The New York State Task Force on Life and Law, in an exhaustive study entitled *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994),[5] noted that "[i]ndividuals with serious chronic and terminal illness face an increased risk of suicide—some studies suggest that the risk for cancer patients is about twice that of the general population." New York Task Force at 13. The New York Task Force summed up the link between terminal illness and depression as follows:

> Depression may coincide with other medical conditions for several reasons. First, the medical condition may biologically cause depression. Second, the condition may trigger depression in patients who are genetically predisposed to depression. Third, the presence of illness of disease can psychologically cause depression, as is often observed in patients with cancer. Finally, especially for cancer patients, some treatments or medications have side effects that cause depressive moods or symptoms.

New York Task Force at 15. However, the task force found that

> [i]t is a myth . . . that severe clinical depression is a normal and expected component of terminal illness. Healthy individuals, including health care professionals, often believe that it is normal for terminally ill patients to experience major depression. They understand feelings of hopelessness as expected and

[5]The task force was convened in 1985 by Governor Mario Cuomo, who charged the twenty-five-member body with developing recommendations for state public policy on a variety of issues. The report, hereinafter referred to as "New York Task Force," has been recognized as authoritative and relied upon by the Ninth Circuit Court of Appeals in the case of *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995).

> rational given the patient's condition and prognosis.

New York Task Force at 16. Further, some will clearly be at risk for depression at the time when they take the lethal overdose, when Measure 16 provides no safeguards to screen out those who are acting incompetently.

Third, primary care physicians have difficulty in diagnosing depression. In the *Affidavit of Patricia Wesley, M.D.*,[6] Dr. Wesley, a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, cites a study by "David Clark, a major researcher in suicides, and others," of men 65 years and older who committed suicide. *Id.* at ¶ 26 (*citing* David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities*, 8 Issues in Law & Med. 147, 152 (1992)). The study showed that

> 25% had been to a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. These contacts were for vague physical complaints. The general physician did not, and probably could not have, picked up either the psychiatric condition or the suicidal intention, at least as they were diagnosed retrospectively, by the psychological autopsy technique used in this study.

Id. Dr. Wesley concluded:

> The above data indicate that it is not an easy task to diagnose either psychiatric illness or suicidality, and that such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-

[6]Supp. E.R. 11, C.R. 28. Patricia Wesley, M.D., is an assistant clinical professor of psychiatry in the Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, where she supervises psychiatric residents in their outpatient psychotherapy work. Her other professional responsibilities include the evaluation and treatment of seriously and persistently mentally ill individuals in two outpatient facilities in New York City. One of these facilities exclusively serves individuals 55 and over, many of whom have significant medical problems. While she does not personally manage their medical conditions, she has gained considerable exposure to the impact of significant medical illness on psychological functioning. Her affidavit was quoted and cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

> line, untrained physicians to perform this vital screening function. It will inevitably be done poorly, and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Id. at ¶ 27. Dr. David C. Clark concurs that psychiatric evaluation and treatment is necessary for terminally ill persons seeking suicide:

> The definitions of "attending physician" and "consulting physician" in the Act permit any licensed physician, regardless of experience or specialty training, to function in these roles. There is no requirement that either party have any knowledge or expertise in evaluating mental status, cognitive state and functioning, or psychiatric disorder beyond the fundamentals most physicians are exposed to in medical school. The medical/surgical literature is very clear and consistent in showing that medical/surgical general practitioners and specialists (other than psychiatrists) fail to recognize at least half of all cases of clear-cut major depressive illness in their own practices—i.e., among their own patients—and then they are not successful at recognizing the more severe half of cases. It is my professional opinion that the Act should include a requirement that trained and experienced mental health professionals examine each patient who makes a request for assisted suicide. This would protect people who, in the state of clinical depression, request assisted suicide without the opportunity for treatment.

Affidavit of David C. Clark, Ph.D.[7] at ¶ 27. The latest literature on suicidology confirms the above facts. In the September-October 1995 issue of *Psychomatics*, Harvard Medical School psychiatrists Block and Billings confirm that:

> [d]epression and organic mental disorders are commonly seen

[7]Supp. E.R. 89, C.R. 32. David C. Clark, Ph.D., is Professor of Psychiatry, Psychology, and Preventive Medicine, and Director of the Center for Suicide Research and Prevention, at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. His supplemental affidavit was cited by the Oregon District Court at 869 F. Supp. at 1501 n.4.

> among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. Because of the irrevocability of hastening death, decisions about competency must be especially rigorous. Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices. Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential.

Susan M. Block, M.D. & J. Andrew Billings, M.D., *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 5 Psychosomatics 445, 452 (1995). In the August 1995 issue of the *American Journal of Psychiatry*, a team of seven psychiatrists and other researchers reported the results of a Canadian study on the desire for death in the terminally ill—that terminally ill persons who desire death do so because of depression—and urged psychiatric involvement in such cases. Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995).

The Oregon record clearly shows on empirical evidence that there *is* "reason to believe" that primary care physicians, who are concededly not specially trained to diagnose and treat depression, are not capable at discovering, diagnosing, and treating depression. Finally, this fact is confirmed by the New York Task Force:[8]

[8]The New York Task Force may be viewed as an impartial voice because it included both persons who favored and opposed assisted suicide personally, but all agreed that, even with attempted safeguards, there is too great a "risk of harm" in implementing a regime of state-endorsed assisted suicide, a risk which "is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized group." New York Task Force at 119.

> Even psychologists and psychiatrist who routinely treat and diagnose depression may have limited experience doing so for patients who are terminally or chronically ill. For those patients, clinicians must be able to distinguish realistic sadness and sense of loss that accompanies such illness from severe clinical depression or the psychiatric disorders that impair decision-making capacity. These disorders are prevalent in those patients who ultimately choose to commit or attempt suicide.

New York Task Force at 127-28.[9]

Fourth, depression[10] is a major factor leading to suicide. "Suicide is the eighth leading cause of death in the United States" and "is a major health problem." *Affidavit of David C. Clark, M.D. (Supp. E.R. 89; C.R. 32; at ¶ 3).* "Those aged sixty-five and over make up 12% of the population but account for 21% of all suicides." *Id.* Major suicide researcher Dr. David Clark reports:

> There is considerable agreement among the findings from the large community-based psychological autopsy studies on the relationship between major mental disorder and death by suicide. Never less than 88% of the subjects qualified for a psychiatric diagnosis at the time of the suicide (never less than 94% in all but one study). . . . Thus suicides rarely occur in

[9]Even where depression is diagnosed, it is often undertreated, New York Task Force at 127, leaving terminally ill persons at risk for suicide both because depression is undiagnosed and because it is undertreated.

[10]The term "depression" is used here and elsewhere herein as a shorthand expression for a range of judgment impairing psychopathologies. Because space and readability do not permit continued reference to a string of psychiatric diagnoses that may lead to suicide, necessity dictates that a shorthand substitute be used. The *Affidavit of David C. Clark, Ph.D.* (Supp. E.R. 89; C.R. 32) sets forth the wide range of psychopathologies which lead to suicide, including depression. Other treatable causes of suicidal ideation and attempt include unrelieved pain and suffering, substance abuse, organic problems, and side effects of certain treatments. While these latter are not psychiatric problems, they represent treatable conditions which can lead to suicidal impulses and should be recalled when the shorthand term "depression" is used herein.

> the absence of major psycho-pathology.

Id. at ¶ 4. Further, "15% of persons with major depression die by suicide." *Id.* at ¶ 6. A Canadian study on the desire for death in the terminally ill, reported in the August 1985 issue of the *American Journal of Psychiatry*, confirms the connection: "in the logistic regression analysis, depression emerged as the only predictor for the desire for death." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). The authors of the article cautioned that: "our findings indicate that a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." *Id.* A 1986 study, reported in the *American Journal of Psychiatry* questioned, on the basis of empirical evidence, "[t]he role of terminal illness, physical decline, or chronic pain as a reason for suicide." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 19. Dr. Clark reports of the study that

> Brown and colleagues, in a study of hospice patients diagnosed with terminal illness, severe pain, disfigurement, or disability, found that the great majority of these patients did not desire to die by suicide. Of the small percentage who expressed any wish to die, all met diagnostic criteria for major depressive illness.

Id. at ¶ 20.[11] From this and other evidence, Dr. Clark concluded:

> While it is compelling to assume that many persons with chronic, painful, or terminal illnesses will choose to end their suffering prematurely by opting for suicide, in fact this type of choice, usually referred to as "rational" suicide, is rarely seen in hospital and hospice work. Except in those cases where physical illness is accompanied by a major depressive illness,

[11]Such empirical evidence belies the notion that it is normal and rational for persons with a terminal illness to be depressed and want to kill themselves. *See also Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶¶ 9-12, 19-21, 23-25.

> the great majority of patients spontaneously reject the suicide option and choose to die naturally. The majority of terminally ill patients cling to life throughout their illnesses. Among older person, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2% of female deaths are attributable to suicide.

Id. at ¶ 19. Clark concludes that

> [t]o wish to end life by killing oneself is almost always a serious symptom arising from a temporary psychiatric illness, even when the person is terminally ill. While the subtlety and complexity of depressive illnesses often make it difficult for loved ones to recognize the gravity of the problem, it is generally a mistake to assume that a wish to die or end one's own life is a rational, carefully thought-through decision justified by a person's life situation or health status. One should always suspect that an unrecognized psychiatric illness has silently, invisibly influenced the judgment of a patient opting for suicide. When a patient asks to die, the burden of proof should lie with those who wish to defend as "rational" a decision to die by suicide.

Id. at ¶ 31. The Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) provides corroborating evidence of the link between depression and suicide, conceding that, by this criteria, half of all persons committing suicide "suffer from a psychiatric disorder" and that "one-third of all suicides suffer from clinical depression." *Id.* at ¶ 5.[12] Finally, the New York Task Force documented that "As explained by one sociologist who studied suicide: 'It is undeniable that all persons—100 percent—who commit suicide are perturbed and experiencing unbearable psychological pain.'" New York Task Force at 95 n.65 (quoting Edwin S. Schneidman, *Rational Suicide and Psychiatric Disorders*,

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[12]Other treatable reasons people seek suicide include unrelieved pain and suffering, New York Task Force at 128; substance abuse, *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89, 91 ¶ 4; C.R. 32); psychological suffering, New Task Force at 94-95; and psychological pressure, *Affidavit of Gary E. Lee, M.D.* (Supp. E.R. 159, 162 ¶ 9; C.R. 36).

326 New Eng. J. Med. 889 (1992)).

Fifth, depression is treatable. "[D]epressed patients generally respond well to standard treatments for depressive illness—psychotherapy and some antidepressant medication." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 21. "In response to treatment, patients with terminal illnesses and intractable pain are usually grateful that no one facilitated their suicide while they were temporarily depressed or having acute difficulties with pain." *Id.* Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) declares that Major Depressive Disorder, the "type of mood disorder that is often associated with suicidal states," "can usually be treated effectively with antidepressant medication." *Id.* at ¶ 4.

Sixth, major life decisions should not be made while one is depressed. As already noted, the *Affidavit of Carol J. Gill, Ph. D.* (Supp. E.R. 21; C.R. 29) establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Dr. Gill continues: "[c]lients in crisis therapy are, therefore, cautioned not to make any major life decisions within five weeks of a critical life stress. The Act needlessly narrows this window to fifteen days." *Id.* The assertion that important decisions should not be made while one is depressed is uncontested.

Seventh, treatment for depression takes more than 15 days. As noted in the material quoted in the previous paragraph, resolution of acute emotional disorders takes a minimum of five weeks for resolution. This is uncontested. If treated depression will not resolve itself in less than five weeks, then 15 days is clearly too short a time for depression to resolve itself if undetected and untreated.

Eighth, patients with terminal illness are vulnerable to external

pressures and abuse. "[D]emoralizations and a lack of assertiveness may render the depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). *See also Affidavit of William Petty, M.D.*[13]

Ninth, drug overdoses are notoriously unreliable in actually causing death. Dr. Jerome R. Wernow, a pharmacist, has submitted evidence that 25% of assisted suicides will fail, based on the writings of Derek Humphrey, a Measure 16 proponent and a co-founder of the Hemlock Society (which advocates legalization of physician-assisted suicide and euthanasia). *Affidavit of Jerome R. Wernow, Ph.D.*[14] Dr. Wernow also cites evidence that barbiturate poisoning is the "most uncertain way of taking one's life," *id.* at ¶ 8, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage, and protracted suffering for the patient and her family. *Id.* at ¶¶ 9-10.

From all these medical facts, Dr. Patricia Wesley, a psychiatrist teaching at the Department of Psychiatry at Yale, has concluded that

> [a]s David Clark puts it, "when a patient asks to die, the burden of proof should be with those who wish to defend a wish to die by suicide as a rational decision." Oregon's Death with Dignity Act has it precisely the other way round, and regards a terminally ill person's suicidal wishes as deserving of speedy implementation, unless proven otherwise. This law flies in the face of what we know about suicide and the

[13]Supp. E.R. 1, C.R. 23, at ¶ 10. William Petty, M.D., is one of the Plaintiffs in Lee v. Harcleroad (Oregon), and is a physician with offices in Portland, Oregon. Eighty percent of his patients are cancer patients.

[14]Supp. E.R. 169, C.R. 169, at ¶ 7. Jerome R. Wernow, Ph.D., is a pharmacist and biomedical ethicist in Oregon. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1502 n.5.

terminally ill.

Affidavit of Patricia Wesley, M.D. (Supp. E.R. 11; C.R. 28) at ¶ 30. As discussed *infra* this reversal of presumptions from those established by the facts of modern suicidology is irrational and based on erroneous, unscientific stereotypes about why people commit suicide.

The safeguards in Oregon Measure 16 are typical of the type of safeguards being proposed to protect against abuse. However, as can be seen from the above evidence and argument, those safeguards will be inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

II. If a Constitutional Right to Assisted Suicide is Recognized, Any Proposed Safeguards Will Undoubtedly Be Challenged and Frequently Struck Down.

The abortion litigation precedents of the past twenty-five years will control any new constitutional right to assisted suicide. The 9th Circuit declared:

> In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment. Although Casey was influenced by the doctrine of stare decisis, the fundamental message of that case lies in its statements regarding the type of issue that confronts us here: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."

79 F.3d 801, 813-14 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851). Thus, the right to die is founded upon and defined by abortion jurisprudence and precedents. If assisted suicide receives constitutional recognition, it is destined to become a super protected right like abortion.

The super protected right of abortion is illustrated by the fact that abortion safeguards have been repeatedly challenged and

frequently struck down. The following are a few examples of the abortion safeguards which have been challenged and defeated. It is clearly foreseeable that assisted suicide safeguards will also be challenged and defeated.

First, the 1986 case of *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), demonstrates the problem states have in predicting and conforming to this Court's constitutional boundaries in forth in *Roe*.[15] As Justice O'Connor wrote in her dissent to *Akron*, the "bright lines" have become "blurred."[16] The challenged provisions of the Pennsylvania law in *Thornburgh* included an informed consent provision. It required physicians to make available state-prepared information concerning alternatives to abortion, available assistance for alternatives, and objective information regarding fetal characteristics and the possibility of fetal survival.[17] The physician was required to disclose (1) the possibility of unforeseeable psychological and physical risks of abortion,[18] (2) the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care,[19] (3) the liability of the father for child support,[20] and (4) the probable gestational age of the fetus.[21] The court of appeals invalidated all of these provisions on the basis of this Court's decision in *Akron*.[22] We may expect that similarly detailed

[15]Roe v. Wade, 410 U.S. 113 (1973).

[16]Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 455 (1983) (O'Connor, J., dissenting).

[17]18 Pa. Cons. Stat. § 3205(a)(2)(iii) (1983).

[18]*Id.* § 3205(a)(1)(ii).

[19]*Id.* § 3205(a)(2)(i).

[20]*Id.* § 3205(a)(2)(ii).

[21]*Id.* § 3205(a)(1)(iv).

[22]*Thornburgh*, 737 F.2d at 295-96. *See Akron*, 462 U.S. at 444-45. *But see* Brief for the United States, *supra* note 17, at 7-8.

informed consent requirements for assisted suicide will also be struck down.

Pennsylvania also included a parental consent provision which essentially codified the Supreme Court's holding in *Bellotti v. Baird*.[23] The appeals court enjoined enforcement of this until the Pennsylvania Supreme Court promulgated implementing regulations.[24] We expect that minors will also be recognized to have a right to assisted suicide and that parental consent requirements will be closely scrutinized so as to prevent any unconstitutional burden on the minor's exercise of his or her constitutional right to assisted suicide.

The Pennsylvania Act also required physicians to provide reports with a variety of data for statistical purposes.[25] Included was a report of the basis for the physician's determination that the fetus was not viable or "that the abortion [was] necessary to preserve maternal life or health."[26] The court of appeals invalidated these requirements because they were too extensive and complicated and, hence, were likely to increase the cost of an abortion and possibly have a chilling effect on physicians' willingness to perform abortions.[27] Reporting requirements for assisted suicide will likewise be considered unnecessary and burdensome.

Another Pennsylvania provision required health insurers to

[23]18 Pa. Cons. Stat. § 3206 (1983). *See* Bellotti v. Baird, 443 U.S. 622, 648-51 (1979) (*Bellotti (II)*).

[24]*Thornburgh*, 737 F.2d at 297. *But see* Brief for the United States, *supra* note 17, at 4-5.

[25]18 Pa. Cons. Stat. § 3214 (1983) (requiring information included the physician's name, location of facility, woman's age, race and marital status, type of abortion procedure, and any complications).

[26]*Id.* § 3211.

[27]*Thornburgh*, 737 F.2d at 301-02. *But see* Brief for the United States, *supra* note 17, at 9-10.

make available policies that excluded elective abortion coverage (except in the case of rape or incest). These policies would have been mandatorily priced less than policies with abortion coverage.[28] The appeals court invalidated this as an unjustified barrier to a woman's access to abortion.[29] We can be sure that insurance policies will also provide coverage for physician-assisted suicide (clearly a way to reduce the cost of care at the end of life) and we will all pay for it through our insurance premiums.

This Court's holding in *Thornburgh* had major substantive rulings regarding informed consent, reporting requirements, and regulations designed to preserve the lives of viable, aborted fetuses. It invalidated almost every regulation Pennsylvania had passed.

Second, in 1990, this Court decided the case of *Hodgson v. Minnesota*, 497 U.S. 417 (1990). This action was brought challenging the parental notification requirement of the Minnesota Abortion Law. In an eight part majority opinion with four opinions concurring in part and dissenting in part. Of three issues that reached this Court, one provision of the statute was struck down as unconstitutional, and two provisions were upheld. The issues concerned the abortion statute's 48-hour waiting period between notification of parents of minor's intent to obtain abortion and performance of that abortion, and the requirement that both parents be notified of a minor's intent to obtain an abortion.

And third, this Court, in 1992, decided the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Certain abortion clinics and a physician challenged the constitutionality of the 1988 and 1989 amendments to Pennsylvania's abortion statute. The United States District Court for the Eastern District of Pennsylvania held that several sections of the statute were unconstitutional. 744 F. Supp. 1323. The Court of Appeals for the Third District affirmed in part and reversed in

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[28]18 Pa. Cons. Stat. § 3215(e) (1983).

[29]*Thornburgh*, 737 F.2d at 303. *But see* Harris v. McRae, 448 U.S. 297, 316-17 (1980); Maher v. Roe, 432 U.S. 464, 474 (1977).

part. This Court affirmed in part, reversed in part, and held that: (1) the doctrine of stare decisis requires reaffirmance of *Roe v. Wade's* essential holding recognizing a woman's right to choose an abortion before fetal viability; (2) the undue burden test, rather than the trimester framework, should be used in evaluating abortion restrictions before viability; (3) the medical emergency definition in the Pennsylvania statute was sufficiently broad that it did not impose an undue burden; (4) the informed consent requirements, the 24-hour waiting period, parental consent provision, and the reporting and record-keeping requirements of the Pennsylvania statute did not impose an undue burden; and (5) the spousal notification provision imposed an undue burden and was invalid. Four concurring and dissenting opinions were filed. This undue burden test will no doubt be precedent for any constitutional right to assisted suicide.

These three decisions illustrate the complexity of abortion litigation and the fact that abortion safeguards have been repeatedly challenged and frequently struck down. If this Court recognizes a new constitutional right to assisted suicide, these cases will be precedent establishing physician-assisted suicide as a similar super protected right. The 9th Circuit already did so in its decision citing *Roe*, *Thornburgh*, *Webster*, and *Casey* in "defining [a] liberty interest [ ] identical to the approach used by the Supreme Court in the abortion cases." 79 F.3d at 801-03. It also declared, "In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent." *Id.* "[T]he full scope of the liberty guaranteed by the Due Process Clause is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints." *Id.* at 803 (citing *Casey*, 505 U.S. at 848).

III. The Recognition of a Constitutional Right to Assisted Suicide Will Not Be Limited to Persons Who Are Terminally Ill and Mentally Competent.

The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will permit assisted

suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. 79 F.3d at 802. The act of refusing or terminating medical treatment is "subject to a balancing test that is less restrictive [than the compelling but narrowly tailored state interest], but nonetheless requires the state to overcome a substantial hurdle in justifying any significant impairment." *Id.* at 804. Further, the 9th Circuit based its decision squarely on *Cruzan*. *Id.* at 814-16.

However, if a right to assisted suicide is recognized, the right will not be limited to persons who are terminally ill and mentally competent. The 9th Circuit recognized this when it stated: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 816.

Although the 9th Circuit did not reach the equal protection issue (*id.* at 838), the 2d Circuit did. Based on *Cruzan* and other refusal/termination of medical treatment cases, it held that those persons not receiving life-sustaining treatment also have a right to hasten death, by physician-assisted suicide. *Quill v. Vacco*, 80 F.3d 716, 729 (2nd Cir. 1996). Thus, equal protection clause jurisprudence will no doubt require the recognition of a right to euthanasia (e.g. lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights to consent. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

The jurisprudence of cases asserting a right to refuse medical treatment will provide the precedent. The right to refuse medical treatment has roots in both the common law right to be free from invasion of one's bodily integrity, and the notion of battery, which is a rejection of unwanted touching. *Schloendorff v. Society of New*

York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914). However, beginning in 1976 with *In re Quinlan* 70 N.J. 10, 335 A.2d 647, *cert. denied sub nom.* Garzer v. New Jersey, 429 U.S. 922 (1976) (when the New Jersey Supreme Court authorized the removal of a ventilator from Karen Ann Quinlan, who was in a coma), many courts have expanded this right by holding that the U.S. Constitution, through the right of privacy, guarantees to individuals a fundamental right to reject medical treatment, including medical treatment without which they will die. Some courts have explicitly characterized this as a "right to die." The following are several cases illustrating the breadth of the right to die since *Quinlan*. These are the precedents which will control any recognized right to determine the time and manner of death.

First, there are cases where competent persons who were terminally ill requested the right to refuse life support: *Tune v. Walter Reed Army Medical Hospital*, No. 85-0697 (D.D.C. Mar. 4, 1985) (held that competent adult patients with terminal illnesses have a right to determine for themselves whether or not they wish their lives to be prolonged by artificial life support systems).

Second, there are cases where competent persons who were disabled but not terminally ill and requested the right to refuse life-sustaining treatment or tube feeding: *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (held that no compelling state interest in the preservation of human life exists that would outweigh a competent but disabled person's right to terminate treatment because "the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration." 225 Cal. Rptr. at 304);[30] *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (ratified the right to die for competent persons with disabilities who were dependent on life-sustaining treatment in order to live, e.g. those it described as having "an artificially extended life," "artificial survival," and an unchanging interest in hastening "natural death" for lives "irreparably

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[30]Ms. Bouvia has quadriplegia due to cerebral palsy. She has not chosen to exercise her hard won right to die.

devastated by injury or illness.");[31] and *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651 (Ga. 1989) (upheld a lower court decision permitting Larry McAfee to shut off the ventilator that he had used since his accident. The trial judge had ruled that McAfee's right to refuse life-sustaining treatment outweighed the state's interest in preserving life and stated: "The ventilator to which he is attached is not prolonging his life; it is prolonging his death.").[32]

Third, there are cases where the persons are incompetent, but have previously expressed their wishes regarding the use of life-sustaining treatment: *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (held that casual remarks made by a patient prior to the onset of any illness could be sufficient evidence to find that the now incompetent patient would, if competent, decline to receive nutrition and hydration by tube);[33] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) (upheld the state of Missouri's requirement that there be clear and convincing evidence that Nancy Cruzan previously decided to terminate her tube feeding in such circumstances as then existed, but did not require the clear and convincing standard be applicable in all states where removal of life-sustaining treatment and

[31]Kenneth Bergstedt was a thirty-one year old man with quadriplegia who died before the court's decision when his father, his primary caretaker, loosened the ventilator from his trachea after first administering Seconal and Valium. One week later, his father died from lung cancer. *Ailing Father Dies; Quadriplegic Had Ended Own Life for Fear Dad Would Go First*, San Diego Union, Oct. 12, 12,1990, at A27.

[32]*In re* McAfee, No. D-70960 (Super. Ct. Fulton County, Ga. Sept, 7, 1989). At the time, Larry McAfee was a thirty-four year old man with quadriplegia, after a sudden accident that left him disabled and on a ventilator. After joining the United Cerebral Palsy of Greater Birmingham, Georgia, he was trained in voice-activated computers and was employed in computerized design and drafting. He has not exercised his right to die. Applebome, *An Angry Man Fights to Die, Then Tests Life*, N.Y. Times, Feb. 7, 1990, at 1.

[33]Paul Brophy was forty-eight years old, unconscious or noncommunicative due to an aneurysm, but not terminally ill.

nutrition/hydration for incompetent patient was requested);[34] and *In re Browning*, 568 So.2d 4 (Fla. 1990) (authorized surrogates to withdraw life-sustaining treatment and tube feeding, without judicial approval, for incompetent patients who had previously expressed their wishes orally or in writing).[35]

Fourth, there are cases where termination of life-sustaining treatment was approved for persons who were incompetent and never previously expressed their wishes regarding the use of life-sustaining treatment: *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (held that provision of tube feeding constitutes medical treatment that can be withheld from persons who are comatose upon the request of the family);[36] *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (held that a feeding tube could be removed at the request of a guardian based upon the patient's constitutional right of privacy and common law right to informed refusal of medical treatment);[37] *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987) (held that a surrogate decisionmaker may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent);[38] and *In re Smerdon*, slip op. No. A-6031-89T1 (N.J. Super. Ct. App. Div. 1991) (held that a substitute judgment test should be applied when there is no clear and convincing evidence that the incompetent

[34]Nancy Cruzan was thirty-four years old, unconscious or noncommunicative due to an auto accident, but not terminally ill.

[35]Estelle Browning was ninety years old, incompetent due to a stroke, but conscious and communicative. She suffered from an incurable but not necessarily terminal illness. Her living will stated that tube feeding could be withheld or withdrawn if she was terminally ill and death was imminent.

[36]Clarence Herbert, the subject of this lawsuit, was fifty-five years old, comatose, but not terminally ill.

[37]Claire Conroy was eighty-three years old, incompetent but not comatose or in an unconscious state, and not terminally ill.

[38]Nancy Jobes was thirty-one years old, unconscious or noncommunicative due to an accident in surgery, but not terminally ill.

patient, while competent, wished to decline any medical treatment, including tube feeding).[39]

Fifth, there are cases where termination of life-sustaining treatment was approved for persons who had never been competent: *In re Sue Ann Lawrance*, 579 N.E.2d 32 (Ind. 1991) (held that the Indiana Health Care Act permits families to decide, in consultation with a physician, to withdraw life-sustaining treatment, including tube feeding, from never-competent patients in persistent vegetative state, without court approval, where there is unanimity among those with tangible personal or professional interest in the patient).[40]

And finally, there are cases where termination of life-sustaining treatment was approved for persons who were minors: *In re Swan*, 569 A.2d 1202 (Me. 1990) (held that pre-accident declarations made by a minor later left in a persistent vegetative state due to an accident may be found sufficient to satisfy a determination that clear and convincing evidence exists of the minor's decision to discontinue life-sustaining treatment and feeding tubes).[41]

Thus, based on the above decisions, the withdrawal of life-sustaining treatment includes withdrawal of life-sustaining treatment and tube feeding not only for those who are competent, terminally ill, and voluntarily electing to end their lives, but also persons who are comatose, in a persistent vegetative state, or otherwise incompetent, even those who were never competent including minors, whether they expressed their wishes prior to incompetency or not. Terminal illness is not required, only significant disabilities, or pain and suffering. For those who are

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[39]Theodore Smerdon was thirty-nine years old, unconscious and noncommunicative due to a stroke, but responded to pain, touch and smell, and was not terminally ill.

[40]Sue Ann Lawrance was forty-two years old, had never been competent due to mental retardation, was unconscious or noncommunicative due to a fall in 1987, but not terminally ill.

[41]Chad Swan was seventeen years old, unconscious or noncommunicative due to an automobile accident, but not terminally ill.

deemed competent, no psychological examination is required to determine if they are suffering from depression or other psychological disturbance. For those who are deemed incompetent, no clear and convincing evidence of their prior expressed wishes is required, only a surrogate's decision based on substituted judgment. In some states, no prior investigation, hearing, or approval by a court or other state official is required, only the unanimous agreement of family and physicians.

What was universally prohibited under traditional laws only a couple of decades ago, has now become commonplace, without significant safeguards for the patient, whether competent or not. Having achieved this level of casual disregard for human life, especially for those most vulnerable, we are now poised to leap from withdrawal of treatment and tube feeding in order to cause death, to the prescription of lethal doses, and under the equal protection doctrine as established in various precedents, the administration of lethal injections by syringe or intravenous line for those unable to take lethal doses by mouth.

If this Court opens the door of intentional killing by lethal dosing, there will be no effective safeguards for persons who are incompetent, especially persons who are mentally disabled with significant physical disabilities. The precedents cited above make it clear that any new constitutional right of assisted suicide will extend to persons who are not terminally ill, persons who are merely disabled and/or suffering physically, and persons who are comatose, in a persistent vegetative state, or otherwise incompetent.[42]

The question before this Court, although rather narrow in its present construction, is likely to impact the vast majority of the American people. Indeed, it will affect decisionmaking for everyone except those who are lucky enough to die quickly while in relatively good health and still living independently.

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[42]Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Are Not Convincing*, 12 Issues in Law & Med. 113, 129 (1996).

For these reasons it is clear that the recognition of a constitutional right to assisted suicide will not be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

CONCLUSION

For the above reasons, your *amici* respectfully pray this Court (1) to hold that there is no right to assisted suicide in the Constitution of the United States, and (2) to reverse and/or vacate the decisions of the United States Courts of Appeals for the Second and Ninth Circuits.

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Nos. 96-110, 96-1858

IN THE
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OCTOBER TERM, 1996

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Petitioners,
v.
HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

DENNIS C. VACCO, *et al.*,
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v.
TIMOTHY E. QUILL, M.D., *et al.*,
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On Writs of Certiorari to the United States Courts of Appeals for the Ninth and Second Circuits

BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, the American Hospital Association ("AHA"), respectfully submits this brief in support of Petitioners in *State of Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 96-1858.[1]

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[1] The AHA has the written consent of Petitioners and Respondents in both cases to the filing of this brief. Letters indicating their consent have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA.

The AHA has played a significant role in the ongoing debate concerning end-of-life decisions. It has worked vigorously through the legislative and judicial processes to help secure the right of patients, in consultation with their families and their physicians, to forego life-sustaining medical treatment.[2] And it regularly publishes policies and ethical guidelines addressing the roles of patients, families, guardians, physicians, and hospitals involved in termination-of-care decisions.

The AHA and its members have a vital interest in the outcome of *Glucksberg* and *Quill*. If a constitutional right to physician-assisted suicide is recognized, AHA members will be called upon to assist in the suicide of patients on a daily basis in hospitals across the country. In the view of the AHA, recognition of such a right would create an administrative nightmare for hospitals and other health-care providers as courts struggle to define the parameters of this new right. For this and other reasons described below, the AHA joins virtually every medical association and governmental panel to study the issue in opposing the creation of a constitutional right to physician-assisted suicide.

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[2] *See, e.g.*, Brief of the AHA as *Amicus Curiae*, in Support of Petitioners in *Cruzan v. Director of Missouri Dep't of Health*, No. 88-1503 (S. Ct. Sept. 1, 1989) (urging recognition of right to refuse medical treatment).

SUMMARY OF ARGUMENT

The American Hospital Association supports the right of every patient to choose whether or not to accept medical treatment. This right includes the right to forego even life-sustaining medical treatment, including artificially delivered food and water. Patients, in consultation with their families and their physicians, should be able to make such determinations free from government interference. The right of a patient to accept or reject medical treatment is in keeping with a doctor's well-recognized obligation not to force treatment on an unwilling patient. It is also consistent with this Court's precedents and with the deeply-rooted traditions of this country.

A right to physician-assisted suicide, by contrast, finds no basis in the text or structure of the Constitution or in this Court's precedents. Nor is such a right so "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), that it may be deemed "fundamental" or "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). To the contrary, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

The American Hospital Association does not endorse state statutes criminalizing physician-assisted suicide. But the AHA cannot accept the assertion that the Constitution precludes such statutes. Under our system of government, democratically-elected officials should be able to grapple with this difficult issue free from "a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan v. Missouri*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring). Hospitals, medical associations, individual physicians, and their patients and communities should all be able to take part in shaping public policy on this issue based on ethical, medical, and political considerations. The Constitution does not preempt such informed dialogue.

Accordingly, the AHA believes that the Ninth Circuit decision being reviewed by this Court is both wrong and profoundly damaging to our constitutional scheme. The AHA also believes that the Second Circuit erred in failing to recognize a rational distinction between assisted suicide and the right to refuse medical care, which the AHA has long-championed.

ARGUMENT

I. THERE IS NO CONSTITUTIONALLY-PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE

A. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Has No Basis in the Text or Structure of the Constitution or in This Court's Precedents

This Court has been understandably reluctant in recent years to expand the range of substantive due process rights protected by, though not mentioned in, the Constitution.

> The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional laws having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986).

The Ninth Circuit does not suggest that there is any basis in the language or design of the Constitution for a right to physician-assisted suicide. Rather, the court of appeals attempts to base its decision on two prior decisions of this Court, neither of which will bear that weight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 812-16 (9th Cir. 1996) (relying on *Cruzan* and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)).

In *Cruzan*, 497 U.S. at 278, the Court correctly recognized that its prior decisions supported "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." At common law, every individual had a right to "bodily integrity," to be free of any physical intrusion without consent. Any unconsented to touching was a battery. Out of this right to be free of battery grew the doctrine of "informed consent" and its "logical corollary," which is that "the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 269-70. The right to refuse treatment was universally recognized in state law cases and in a series of Due Process Clause decisions leading up to *Cruzan*. *Id.* at 269-78.

In *Cruzan*, the Court assumed without deciding that "under the general holding of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest." *Id.* at 279. In other words, the Court assumed that the long-recognized right to refuse medical treatment includes the right to refuse even treatment necessary to sustain life. The Ninth Circuit has taken that assumption, which was well-grounded in the Court's precedents, and run with it into a wholly "uncharted area" where the "guideposts for responsible decisionmaking . . . are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992).

The Ninth Circuit claims that "*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death." 79 F.3d at 816. From there, the court of appeals finds that if an individual has a right to commit suicide, he must have a right to assistance in committing suicide. Otherwise, "the state's prohibition on assistance [would] unconstitutionally restrict[] the exercise of that liberty interest." 79 F.3d at 801 (citing *Roe v. Wade*, 410 U.S. 113 (1973)). And from a right to physician-assisted suicide, the Ninth Circuit—acknowledging that the question is not even before it, but apparently unable to contain its momentum—proceeds to a right to physician-administered suicide (*i.e.*, voluntary euthanasia). *Id.* at 831.

By this series of little or not so little steps, a complete perversion of the Court's holding in *Cruzan* is effected. The ultimate basis for the right to decline medical treatment recognized in *Cruzan* lies in the common law of battery. Unwanted medical care is an unconsented to touching, and it is in that sense that it implicates the liberty interest protected by the Due Process Clause. But physician-assisted suicide has nothing to do with an unconsented to touching. It involves making it possible for the patient himself to take a voluntary action. Neither touching (*i.e.*, the actual administration of medicine) nor a lack of consent is involved. The protection of bodily integrity from unwanted physical invasions is simply not implicated by physician-assisted suicide.

As discussed in more detail below, there is a legitimate and important policy distinction between a patient's decision to decline all treatment and a doctor's decision to prescribe drugs for the express purpose of inducing the patient's death. For present purposes, however, it is enough to recognize that a right to physician-assisted suicide finds no conceivable support in the common law of battery and in the informed consent and related cases

upon which the *Cruzan* Court relied. Torn from its moorings in history, the right championed by the Ninth Circuit is a free-floating derelict that can only wreak havoc on our constitutional structure.

A right to physician-assisted suicide finds even less support in *Planned Parenthood v. Casey*. The Ninth Circuit leans heavily on a single paragraph plucked out of the *Casey* plurality's 30-page opinion, a paragraph moreover that discusses only in the most general terms the constitutional significance of "intimate and personal choices" that are "central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. From this the Ninth Circuit remarkably concludes that the Supreme Court has provided an "almost prescriptive" mandate requiring recognition of a fundamental liberty interest in assisted suicide. 79 F.3d at 813 (citations omitted).

But *Casey* was never intended to be read so broadly. In the first place, the plurality's opinion rests at heart upon *stare decisis* principles, upholding the abortion right largely because of the need to protect and respect prior court decisions in the abortion field extending back to *Roe v. Wade*. *See Casey*, 505 U.S. at 854-69. Indeed, the plurality's reliance on *stare decisis* in Section III of its opinion was entirely sufficient to decide the controversy before the Court in *Casey*. Consequently, the very general autonomy discussion found earlier in Section II upon which the Ninth Circuit so heavily relied is no more than dicta of a mere plurality of the Court.

Even if *Casey* is read as a re-approving (and not just declining to overrule) a due process right to abortion, the two contexts are entirely different. As Judge Noonan noted below, "[i]t is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context." *Compassion in Dying v. State of Washington*, 49 F.3d 586, 590 (9th Cir. 1995). This Court has concluded that abortion does not involve the taking of a human life,

because a fetus is not a "person" under the Fourteenth Amendment. *Roe*, 410 U.S. at 157-58. But no one could claim that physician-assisted suicide is not the deliberate taking of a human life, and that fact gives rise to legitimate state interests in preventing physician-assisted suicide that are not implicated in the abortion context.

The Ninth Circuit's reading of *Casey*'s autonomy discussion goes too far in other respects as well. If the Constitution protects as a fundamental liberty interest every "intimate" or "personal" decision, as the Ninth Circuit suggests, this Court must acknowledge frankly that *Bowers v. Hardwick*, 478 U.S. at 191, is no longer the law (something the Ninth Circuit strongly hints should happen). And it must be prepared for future automony-based constitutional challenges to laws banning any private consensual act of significance to the participants in defining their "own concept of existence." *Casey*, 505 U.S. at 851. As Judge O'Scannlain queried: "If physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and, indeed, the use of illicit drugs?" *Compassion in Dying v. State of Washington*, 85 F.3d 1440, 1444 (9th Cir. 1996) (dissenting from denial of rehearing en banc by the full court).

Finally, even if the Court could somehow restrict the right of "intimate and personal choice" to physician-assisted suicide, it would still be enmeshed in endless problems of line drawing of the sort that have plagued the Court's abortion jurisprudence. As the Ninth Circuit itself conceded, the federal courts will have to determine what "appropriate, reasonable, and properly drawn safeguards" states are permitted to devise to control physician-assisted suicides. 79 F.3d at 833. Once again, states will be legislating "against a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).

This process of uncertainty will place a severe burden on hospitals and other health care providers that will be called upon to provide physician-assisted suicide. They will be acting against a background of uncertainty and potential liability for years to come. Moreover, they will be under great pressure to provide a service that some providers consider antithetical to the integrity of their profession and their own sense of ethics. The patient's right to abortion has been distorted by at least one court into an obligation placed on a private hospital—deemed "quasi-public" in part because of its acceptance of some public funding, but primarily because "[t]he hospital was the only one serving the community"—to make its facilities available for non-therapeutic (elective) abortions. *Mat-Su Coalition for Choice v. Valley Hosp. Assoc.*, No. 3PA-92-1207, slip op. 11 (Alaska Super. Ct. Feb. 9, 1993). If the courts feel free to override the conscience of health care providers in that context, there is a danger they will do so here as well.

Justice O'Connor stated in *Casey* that abortion is "unique" in American constitutional jurisprudence. *See* 505 U.S. at 852 (concurring). Given the problems of legitimacy and line-drawing inherent in the Court's abortion rulings, it would be a "great misfortune" if the Court were to embark on a comparable venture here. *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring).

B. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Is Not So Rooted in Our Traditions That It May Be Deemed "Fundamental"

Before it recognizes any new liberty interest, the Court has required that the asserted interest be "so rooted in the traditions and conscience of our people as to be ranked as fundamental."[8] Far from being rooted in our tradi-

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[8] *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934); *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977) (requiring proof

tions, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

Forty-five states and the District of Columbia currently forbid assisted suicide.[4] At the time of the adoption of the Fourteenth Amendment in 1868, "twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisted suicide." Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone & Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 76 (1985). Moreover, "most States that did not explicitly prohibit assisted suicide in 1868 recognized, when the issue arose in the 50 years following the Fourteenth Amendment's ratification, that assisted and (in some cases) attempted suicide were unlawful." *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citing Marzen *et al.*, 24 Duquesne L. Rev. at 77-100).

At common law, assisted suicide was also forbidden. As a prominent 19th century treatise explained, the consent of the victim is "wholly immaterial to the guilt of the person who causes [his death]."[5] Court after Court reached the same result.[6]

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that the asserted interest is "deeply rooted in this Nation's history and tradition"); *Michael H. v. Gerald D.*, 491 U.S. 110, 123 (1989) (plurality opinion) (insist[ing] that the asserted liberty interest be rooted in history and tradition").

[4] *See* Edward R. Grant and Paul B. Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Ore. L. Rev. 449, 462 (1995) (citing state statutes).

[5] Sir James Fitzjames Stephen, 2 *A History of the Criminal Law of England* 16 (1883).

[6] *See, e.g., Wharton's Criminal Law* § 46, at 232-33 (Charles E. Torcia, ed. 1978); Wayne R. LaFave & Austin W. Scott, Jr., *Criminal Law* 477 (2d ed. 1986); *Gospodareck v. State*, 666 So. 2d 835, 842 (Ala. Crim. App. 1993); *State v. Fuller*, 278 N.W. 2d 756, 761 (Neb. 1979); *State v. Mays*, 307 S.E.2d 655 (W. Va. 1983); *State v. Cobb*, 625 P.2d 1133 (Kan. 1981); *Turner v. State*, 108 S.W. 1139 (Tenn. 1907); *People v. Matlock*, 336 P.2d 505 (Cal. 1959 (*en banc*)); *State v. Bouse*, 264 P.2d 800 (Ore. 1953); *People v. Roberts*, 178 N.W. 690 (Mich. 1920).

Moreover, neither the common law nor any statutory proscription of assisted suicide has ever made any distinction based on the physical condition of the suicide or the time left to him. That the suicide was about to die anyway, or would have had a more painful natural death than the one provided him by the assistant, has been treated as no defense to assisted suicide. Thus, in *Blackburn v. State*, 23 Ohio St. 146 (1872), the Ohio State Supreme Court explicitly remarked that

> [t]he lives of all are equally under the protection of the law, and under that protection to their last moment. The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Id. at 163. *See also People v. Roberts*, 178 N.W. at 693 (same); *Commonwealth v. Bowen*, 13 Mass. 356, 360 (1816) (prisoner who persuaded another to comimt suicide can be tried for murder, even though the suicide was scheduled for imminent execution; it is irrelevant "that but a small portion of [the suicide's] earthly existence could in any event remain to him.").

In short, the supposed right to assisted suicide recognized by the court below is unprecedented in the law of this Nation and in our common law origins. Under the circumstances, such a right can hardly be said to be so rooted in our traditions as to warrant constitutional recognition.

C. States Have Compelling Reasons to Ban Physician-Assisted Suicide

Even if the Court were to find some sort of liberty interest in assisted suicide, states can still ban the practice if they have compelling reasons to do so. *Cruzan*, 497 U.S. at 280 (" 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests' ") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Petitioners and their other *amici* describe in detail the various state interests underlying a ban on physician-assisted suicide. The AHA will not repeat that discussion here. Nor does the AHA endorse any conclusion that the balance of considerations, as a policy matter, favors criminalizing physician-assisted suicide. But, as a matter of constitutional law, it should be clear that the various state interests are sufficient to allow a state, if it so chooses, to override any alleged liberty interest of the patient in obtaining assistance to commit suicide.

Herein lies the most offensive aspect of the Ninth Circuit's decision. The court arrogantly and disdainfully dismisses the state interests supporting a ban on assisted suicide simply on the grounds that it disagrees with them. *See* 79 F.3d at 816-32. But there is no single right answer to such a difficult issue as assisted suicide. There are instead a whole series of counterveiling considerations that tug policy makers first in one direction, then in another. Different states, forced to make a choice, will diverge in their approaches.

The Court's suggestion in *Cruzan* that any liberty interest must be balanced against relevant state interests could not have been intended to suggest that there is only one right answer to such questions, much less that the answer lies in the sole possession of the judiciary. As long as a state can articulate compelling policy justifications for banning the practice, the Court cannot substitute its own policy analysis for that of the state. As Judge Kleinfeld explained below: "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." 79 F.2d at 858.

II. THERE IS A RATIONAL BASIS FOR THE DISTINCTION BETWEEN ASSISTED SUICIDE AND THE REFUSAL OF MEDICAL TREATMENT

"It is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio Indep. Sch. Dist. v. Rodriquez*, 411 U.S. 1, 33 (1973). Yet that, of course, is precisely what the Second Circuit has done in concluding that the State of New York cannot allow patients to refuse life-sustaining medical treatment while, at the same time, forbidding physician-assisted suicide. The Second Circuit, just like the Ninth, has taken the right of a competent adult to refuse medical care and blown it up into a general right to "hasten death," which it then concludes must rationally embrace the right to physician-assisted suicide.

Under this Court's precedents, New York need only establish that the statutory distinction at issue is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). This New York can easily do. Physician-assisted suicide by definition involves an *intention* on the part of both doctor and patient that the patient die. The withdrawal of care, though it may also result in death, need involve no comparable intent on the part of the physician or even the patient. That difference provides ample support for the statutory distinction drawn by New York.

Under New York penal law, and the law of virtually all other jurisdictions, a person is guilty of assisted suicide

only if he "*intentionally* aids another person to commit suicide" (emphasis added).[7] Suicide itself has always been understood as an intentional act.[8] Thus, to be guilty of the crime of assisted suicide, one must intentionally aid another person who intends to kill himself.[9]

New York's assisted suicide law is absolute and creates no classifications on its face. *All* intentional acts of aiding another intentionally to kill himself are proscribed. Nonetheless, the Second Circuit reasons that New York treats similarly-situated classes of persons differently because it

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[7] N.Y. Penal Law § 125.15 (McKinney 1987); *see also id.* at § 120.30 ("A person is guilty of promoting a suicide attempt when he *intentionally* . . . aids another person to attempt suicide.").

[8] *See, e.g.*, Model Penal Code and Commentaries § 210.5, comment 1, at 91-92 (1980) (common law crime of suicide "consisted of intentional self-destruction by a person of sound mind and body"); John Bouvier, Law Dictionary and Concise Encyclopedia 3178 (3d ed. 1914) ("To be guilty of [suicide], the deceased must have had the will and intention of committing it, or else he committed no crime."); Sir Matthew Hale, 1 *Pleas of the Crown* at 411 (1847) (crime of *felo de se* requires proof that suicide "voluntarily kill[ed] himself"); E. Wingate, *Justice Revisited: Being the Whole Office of a County Justice of the Peace* 61, 88 (1661) (the crime of *felo de se* requires proof that a person "destroy[ed] himself out of premeditated hatred against his own life"); Sir William Blackstone, *Commentaries on the Laws of England* 189 (1769) (act must be undertaken "deliberately" or as part of an "unlawful malicious" act).

[9] The intent component of assisted suicide and suicide has always been critical to prevent overinclusiveness problems. If the mental element required were "knowledge" that death would result, many martyrs would be "suicides" and those who aided them guilty of assisted suicide. And the same would hold with soldiers who went ashore at Normandy and those who supported them. Several hundred years ago Hale illustrated the absurdities that would result if intent were not part of the very definition of suicide: "If A., with an intent to prevent gangrene beginning in his hand doth without any advice cut off his hand, by which he dies [bleeding to death], he is not thereby *felo de se*, for tho it was a voluntary act, yet it was not with an intent to kill himself." Hale, 1 *Pleas of the Crown*, at 412.

recognizes a patient's right to withhold or withdraw life-sustaining medical treatment while at the same time it refuses to allow "self-administr[ation] [of] prescribed [lethal] drugs" to "hasten death." *Quill v. Vacco*, 80 F.3d 716, 729 (1996).

This reasoning overlooks a key distinction. In *all* cases where the physician prescribes and the patient administers a lethal dose of drugs to hasten death, the *intent* of both doctor and patient is to see the patient die. Indeed, if the patient continues to live by accident, that represents a frustration of the patient's and physician's will, and to effectuate their plans the parties will have to try again.[10] By contrast, in refusal of care cases, the physician and patient may *know* that removing the respirator or stopping the feeding tube will result in death, but they need not *intend* it. If the patient somehow manages to live without the rejected care, it may actually be a cause for celebration, not regret or frustration.[11]

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[10] *See "If the Drink Does Not Work, The Syringe Is At Hand"*, Nederlands Dagblad (July 6, 1994) (quoting Dutch physician) (translated from the Dutch: "Als het drankje niet werkt, dan ligt de spuit al klaar").

[11] The Second Circuit muddies the waters by suggesting physicians assisting suicide intend only to relieve suffering. *See Quill*, 80 F.3d at 730 ("[a]nd what business is it of the state to require the continuation of agony"). But the physicians-respondents in both the Second and Ninth Circuit cases themselves *concede* they *intend* to see their patients die (if only as a means to their *further* intention of relieving suffering). *See, e.g., id.* at 719 (physicians conceding that they wish to violate New York law banning intentionally aiding in suicide). And, indeed, they must make that admission: if they lacked the intent to help kill they would by definition be innocent of assisting suicide and lack standing to pursue this claim. Physician-respondents readily concede, in sum, that they *intend to kill*, even if they are motivated by a further intent to stop suffering. *See* New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, at 61 (May 1994) ("it is significant that intent does not mean motive, and does not imply an evil state of mind.

Even where death is inevitable, the decision not to prolong life at the cost of invasive care is not the same as the intent to cause death. It has become increasingly common for patients either to refuse "basic" life-sustaining care such as feeding or hydration tubes, or to leave behind "living wills" requiring that such treatment not be given. No intent to die is necessarily involved in such instructions. To the contrary, the intention is usually to avoid the discomfort and perceived indignity such care involves.[12]

If a soldier accepts death in battle to avoid dishonor in running away, he does not commit suicide, and the general who orders him into battle does not murder him. Similarly, if a patient accepts death to avoid the pain and indignity of continued treatment, he does not commit suicide, and the doctor who respects his wishes does not murder him. "To call these judgments [to refuse or withdraw treatment] 'intending' death distorts what actually happens. . . . [I]f I stop shoveling my driveway in a heavy snowstorm because I cannot keep up with it, am I thereby intending a driveway full of snow?" Daniel Callahan, *The*

The fact that the physician acts benevolently, out of compassion for the patient, would not be a defense to liability [for assisted suicide]").

[12] *See, e.g.*, New York State Task Force at 146 ("[i]n many cases, the patient must also be physically restrained to accept treatment"); Alan Meisel, *The Right to Die* 98 (1992 Supp.) (noting that up to 53% of patients require physical restraints to keep them from removing feeding and hydration tubes); *id.* (noting that feeding and hydration tubes can cause substantial pain and discomfort since tubes inserted directly into the stomach necessitate a surgical procedure which "may lead to leakage of acidic stomach contents, causing sores and infections"); Jacquelyn A. Beatty, Comment, *Artificial Nutrition and the Terminally Ill: How Should Washington Decide?* 61 Wash. L. Rev. 419, 425 (1986) (nasogastric tubes can "painfully irritate the patient, causing bleeding and ulceration. Tubes can be misplaced, which may lead to infection and death. Aspiration-included pneumonia is a frequent complication").

Troubled Dream of Life: Living with Mortality, 77-78 (1993).[13]

In the course of recognizing the right to refuse medical care, New York State has explicitly recognized that withdrawing medical care need not involve any intent to kill and, thus, in no way sustains or supports a right to assist suicide. *See Eichner v. Dillon*, 426 N.Y.S.2d 517, 544 (1980) ("the withdrawal of the respirator evinces only an intent to . . . allow the processes of nature to run their course"). Court after court across the country has likewise found that because the patient and physician at issue sought to discontinue medical care without *intending* death, their actions did not constitute suicide or implicate laws banning assisted suicide.[14]

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[13] It is commonplace for Jehovah's Witnesses or Christian Scientists to refuse blood transfusions or life-saving surgery and die as a direct result, yet we hardly call these acts of suicide because no *intent* to die is involved. Death may be accepted as a consequence, but it is not purposely sought.

[14] *See, e.g., McKay v. Bergstedt*, 801 P.2d 617, 625-26 (Nev. 1990) (holding refusal of life-sustaining care not tantamount to suicide since "Kenneth harbored no intent to take his life . . . he did not seek his own destruction. Unlike a person bent on suicide, Kenneth sought no affirmative measures to terminate his life . . . he asked no one to shorten the term of his natural life free of the respirator"); *Application of the President & Directors of Georgetown College*, 331 F.2d 1000, 1009 (D.C. Cir. 1964) (Skelly Wright, J.) (in case where patient refuses blood transfusion, "[t]he Gordian knot of this suicide question may be cut by the simple fact that Mrs. Jones did not want to die."); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. App. 1978) ("The testimony of Mr. Perlmutter . . . is that he really wants to live, but to do so, God and Mother Nature willing, under his own power. This basic wish to live plus the fact that he did not self-induce his horrible affliction, precludes his further refusal of treatment from being classed as attempted suicide."); *In re Claire C. Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (declining life-sustaining treatment distinguishable from suicide because it "merely allows the disease to take its natural course"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. App. 1986) (a "decision to allow nature to take its course is not equivalent

The State surely has a legitimate interest in choosing not to wade across the moral Rubicon that has always separated intentional killings from unintentional ones. *See, e.g.*, New York State Task Force at 112 ("[f]or many, the prohibition against actively and intentionally killing innocent persons represents a basic moral and social norm. Diverse philosophical and religious perspectives affirm this view."); House of Lords, *Report of the Select Committee on Medical Ethics* 53 (1994) ("[t]o distinguish between murder and 'mercy killing' would be to cross the line which prohibits intentional killing, a line which we think essential to preserve."). And this interest is not diminished by the fact that—in some class of cases involving the refusal of care—the waters of that river may appear muddy.

CONCLUSION

For the reasons stated above, the judgments in *Glucksberg* and *Quill* should be reversed.

Respectfully submitted,

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November 12, 1996

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to an election to commit suicide with . . . parties aiding and abetting therein").

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In The

Supreme Court of the United States

October Term, 1996

STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

DENNIS C. VACCO, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Courts Of Appeals
For The Ninth And Second Circuits

BRIEF OF AMICUS CURIAE RICHARD THOMPSON OAKLAND COUNTY PROSECUTING ATTORNEY IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICUS[1]

The Court of Appeals for the Ninth Circuit has discovered a constitutionally-protected liberty interest to medical assistance for a competent, terminally-ill, adult person who has chosen to commit suicide. This liberty interest is claimed as a component of the due process clause of the Fourteenth Amendment. The Court of Appeals for the Second Circuit has rejected this new constitutional right based on due process, but has held that a statute which precludes willing physicians from prescribing drugs to competent terminally-ill adults who wish to end their lives using these drugs violates the equal protection clause of the Fourteenth Amendment. U. S. CONST. amend XIV, § 1.

Petitioner State of Washington will explain how the Ninth Circuit erred in announcing a new constitutional right grounded in due process. Petitioner Vacco will explain how the Second Circuit erred in finding a violation of the equal protection clause. Numerous other amici will address associated concerns implicated by recognition of a new constitutional right to so-called physician-assisted suicide, or the "right to die with assistance."[2]

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[1] Letters of consent have been sent to the Clerk of the Court pursuant to Rule 37.3.

[2] Following the modern tenet that the first step in gaining public support for an idea is to identify the concept in the most positive manner, supporters of physician-assisted suicide generally identify the issue as "the right to choose the manner and time of one's death" or "the right of terminally-ill competent adults who are suffering unremitting and unremediable pain to choose when and how to end their suffering." In other words, they try to use a label which invokes a right to personal autonomy (*i.e.*, the "right to choose"). However, just as "a rose by any other name is still a rose,"

For example, the American Medical Association will be able to advise this Court of the impact on the medical profession which will result from recognition of a new constitutional right to die with physician assistance. Such a right would initiate a change in the traditional role of doctors as healers who are ethically sworn to "do no harm."

Moreover, in this day of escalating medical costs, debate over a national health care system, constant medical advances aimed toward prolonging life, and an aging population, there will inexorably be pressure on doctors, nurses, and relatives of terminally-ill patients to cut short nature's course. The patients themselves will also feel pressure to end their lives to save often scarce and limited family financial resources and to avoid being a burden on their loved ones.

Advocates for the physically or mentally disabled will be able to advise this Court of the pressure that recognition of such a right will put on disabled persons, who all too often are already marginalized or ignored by society.

Medical ethicists can inform this Court, as Daniel Callahan has written, that

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euthanasia by any other name is still euthanasia. In Y. Kamisar, *Physician-assisted suicide: the last bridge to active voluntary euthanasia*, in Euthanasia Examined (J. Keown ed. 1995), Professor Yale Kamisar observes at page 225: "Some 30 years ago an eminent constitutional law scholar, Charles L. Black, Jr., spoke of 'toiling uphill against that heaviest of all argumental weights – the weight of a slogan.' I am reminded of that observation when I confront the slogan the 'right to die.' Few rallying cries or slogans are more appealing and seductive than the 'right to die.' But few are more fuzzy, more misleading, or more misunderstood."

> [t]he proposal to legalize euthanasia and assisted suicide is nothing less than a proposal to add a new category of acceptable killing to those already socially legitimated. To do so would be to reverse the long-developing trend to limit the occasions of legally sanctioned killing (most notable in the campaigns to abolish capital punishment and to limit access to handguns). Civilized societies have slowly come to understand how virtually impossible it is to control even legally sanctioned killing. No matter how carefully safeguards are fashioned, abuse and corruption are invited.

D. Callahan, *The Troubled Dream of Life* (1993), pp 104-105.

Review of this Court's own writings will alert the Court that recognition of a new constitutional right to assisted suicide will start an inexorable process of enlargement of that initially limited and narrowly-defined right. As this Court stated in *United States v 12 200-ft Reels of Super 8mm Film*, 413 U.S. 123, 127 (1973):

> * * * The seductive plausibility of single steps in a chain of evolutionary development of a legal rule is often not perceived until a third, fourth, or fifth "logical" extension occurs. Each step, when taken, appeared a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance. This kind of gestative propensity calls for the "line drawing" familiar in the judicial, as in the legislative process: "this far but not beyond." * * * .

This Court also recognized this "seductive plausibility of single steps in a chain" in *Boyd v United States*, 116 U.S. 616, 635 (1886). Justice Bradley, writing for the majority, in response to the government's argument that compelling the defendants to turn over an invoice was an

inconsequential matter that didn't really implicate search and seizure concerns, cautioned:

> It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure. . . . [The Courts'] motto should be *obsta principiis*.

Or, as Professor Kamisar has observed in Y. Kamisar, *When is there a Constitutional "Right to die"? When is there No Constitutional "Right to live"?*, 25 Georgia L Rev 1203, 1227 (1991):

> However, what we cannot do – perhaps cannot even think about doing – in one step we are often able to do in two or three. Professor Schneider has called this "a psychological aspect of slippery slopes: they work partly by domesticating one idea [say, disconnecting the respirator] and thus making its nearest neighbor down the slope seem less extreme and unthinkable." [Footnote omitted.]

Both petitioners and amici can inform the Court of the certainty that recognition of a new constitutional right will inevitably start our society on a trip down that "slippery slope" by cutting off public debate, divesting the legislature of its power to regulate this question, putting the government's imprimatur of approval behind the broad concept of assisted suicide, and thus further acclimatizing the citizenry to the acceptability of that idea and thereby preparing them for further steps down the perilous slope.

However, only one amicus can address this Honorable Court from actual practical experience with the reality of assisted suicide: the Prosecutor of the County of Oakland who has attempted to prosecute the "poster

child" of the assisted suicide movement, Jack Kevorkian, for his role in the deaths of five individuals.

Altogether, by present count (the figure changes virtually day-to-day), Kevorkian has acknowledged being present at the suicides of 45 people. His attorney has further admitted that Kevorkian has assisted some undisclosed number of other "patients" to commit suicide. The majority of these deaths have occurred in Oakland County. Kevorkian resides in, and provides his suicide assistance, mainly in Oakland County. On October 29, 1996, Amicus petitioned for, and obtained, an order to show cause why Kevorkian should not be held in contempt for his alleged continuing violations of a permanent injunction issued by the Oakland County Circuit Court in 1991.[3] On October 31, 1996, Amicus filed new criminal charges against Kevorkian and his associates covering such activities as assisting in suicides, conspiracy, removing dead bodies without the permission of the medical examiner, holding himself out as a practicing physician while engaging in unlawful conduct, and possession of a controlled substance. Thus whatever decision this Honorable Court renders will have its greatest and most immediate impact on the Oakland County Prosecutor's Office.

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[3] This injunction was upheld by the Michigan Court of Appeals, leave to appeal has been denied by the Michigan Supreme Court, and on October 15, 1996, the United States Supreme Court denied Kevorkian's petition for writ of certiorari. *People ex rel Oakland County Prosecuting Attorney v Kevorkian*, 210 Mich. App. 601; 534 N.W.2d 172 (1995), lv. den. 451 Mich. 874; 549 N.W.2d 566 (1996), cert. den. ___ U.S. ___ (No. 96-135; Oct. 15, 1996)

SUMMARY OF ARGUMENT

The on-going campaign by Jack Kevorkian over the past six years to gain recognition for his right to assist people of his choosing to commit suicide has focused national attention on the issue of assisted suicide. Advocates of the practice have insisted that, despite overwhelming historical evidence to the contrary, assisted suicide is a constitutionally-protected right. Those opposed to the recognition of a new constitutional right have pointed not only to the historical and legal record, but also to concerns regarding inevitable abuses which will occur if this Court creates such a new constitutional right.

Amicus submits that the actions of Kevorkian in Oakland County, Michigan, clearly demonstrate that the fears of the opponents of assisted suicide are valid. In fact, virtually all of the arguments against assisted suicide can be illustrated by examination of the "patients" who have chosen to submit their lives to Kevorkian's care.

Kevorkian assists others to commit suicide based solely upon his own determination of whether their request for his assistance is rational. He does not require that they be terminally ill or in unremitting and unremediable pain. He requires only that they suffer from some real or imagined malady that has sufficiently interfered with their "quality of life" as to convince them that their life is not worth living. If they are able to make a request for his assistance in what appears to him to be a competent manner, then Kevorkian is all too ready to grant that request. He engages in a facade of performing a medical procedure with adequate safety checks, but in reality if his subjects are willing to have him assist them to commit suicide, then they invariably receive his assistance and

they die – whatever their true physical and mental condition.

Only by refusing to recognize a new constitutional right to die can this Court hope to prevent an incursion of more "Dr. Deaths" who will offer the sick, infirm, depressed, and aged only the siren song of a painless death.

ARGUMENT

THIS COURT SHOULD NOT RECOGNIZE A NEW CONSTITUTIONAL RIGHT TO DIE WITH THE ASSISTANCE OF A PHYSICIAN UNDER EITHER THE DUE PROCESS CLAUSE OR THE EQUAL PROTECTION CLAUSE WHERE SUCH A RIGHT IS NOT MENTIONED IN THE CONSTITUTION, HAS NO SUPPORT IN THE LEGAL HISTORY OF THIS NATION, IS NOT RECOGNIZED BY THE LAWS OF THE 50 STATES, AND IS INCAPABLE OF BEING CONFINED OR CONTROLLED BY SPECIFIC JUDICIAL OR LEGISLATIVE REGULATIONS.

In the person and practice of Kevorkian this Court can see revealed virtually all of the ills which inevitably afflict the concept of assisted suicide.

Supporters of assisted suicide claim that it would only be utilized by mentally competent adults who were terminally ill and/or suffering great and unremediable pain. Both the Ninth and Second Circuits have affirmed this supposedly "narrow" recognition of a new constitutional right.

Yet given the amorphous nature of the concepts of "terminal" illness and "pain," in actual practice the right could never be restricted only to the terminally ill who were suffering great pain. While some might view terminal illness as a sickness that is sure to kill within days, for

others terminal illness is simply a diagnosis that indicates to some degree of medical certainty that the person afflicted will inevitably die as a direct result of the disease – be it days, weeks, months, or years later. Similarly, what is great and unremitting pain to one person is a level of pain that can be stoically borne by another.

In actual practice such a new constitutional right could *never* be narrowly restricted. The experience amicus has had with Kevorkian bears this out.

In his book, *Prescription: Medicide – The Goodness of Planned Death* (1991), Kevorkian recalls discussing the possible use of his new invention, the "Mercitron" (an intravenous poison drip apparatus), with a potential initial recipient of his services:

> I had to make the patient understand why she was not a suitable candidate for the first use of the Mercitron. Even though she was terribly agonized by an intolerable "quality of life," her condition was not imminently terminal. In order to minimize the passionate (if irrational) storm of criticism certain to be evoked by such a procedure, I realized that ideally it should be in connection with a suffering and indisputably terminal patient – for example, someone dying of incurable and widespread cancer. I explained how that should blunt condemnation of my assisting her as the second case. * * * . [*Id.* at p 219.]

This woman eventually ceased contact with Kevorkian. However, subsequent events demonstrated that Kevorkian had set aside his fears of an "irrational storm of criticism" because none of his first three "test subjects" were terminally ill.

The first woman to meet her death with Kevorkian's active assistance was Janet Adkins, a 54-year-old wife and mother from Portland, Oregon, who was in the early

stages of Alzheimer's disease. She had no physical pain; indeed, she played tennis shortly before she traveled to Michigan to seek Kevorkian's aid in committing suicide. The plain evidence, supported by the autopsy, conclusively demonstrated that she could not even remotely have been considered terminally-ill or suffering from unremitting and intractable pain. In an interview conducted with Adkins before her death, Kevorkian himself states to Adkins' husband (in Adkins' presence): "Of course you realize that she is not terminal." M. Betzold, *Appointment with Dr. Death*, (1993) at p 70. In response to Kevorkian's question, Janet Adkins admitted that she was not in pain. *Id.* at 69. Kevorkian acknowledged in a deposition taken on July 25, 1990, that he personally met Mrs. Adkins for the first time on June 2, 1990. (Tr. of deposition, p 13; App. 5-6) He interviewed her for approximately 40 minutes (while he video-taped the proceeding for posterity) and concluded that "there was enough evidence that she was mentally sound. She knew what she was doing." (Tr. of deposition, p 18; App. 6) Kevorkian admitted he did not physically examine Adkins and merely reviewed medical records that were almost a year old. (Tr. of deposition, pp 24-25; App. 6-7) When asked if Adkins might have been suffering from depression, Kevorkian responded: "Not to be depressed with Alzheimer's is abnormal."[4] (Tr. of deposition, p 27;

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[4] In his testimony before Circuit Judge Alice L. Gilbert in a case seeking a civil injunction, Dr. Kevorkian made the same assertion. When asked whether it was important for him to be able to recognize suicidal ideation in those he evaluated, Kevorkian responded: "Not if they have a crippling physical disease. I don't rely on mental problems. I rely on their physical disease, which then affects the mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal." (Tr. of June 8, 1990, pp 43-44; App. 3)

App. 7) On June 4, 1990, in the back of his rusty 1968 Volkswagen camper, Kevorkian attached his suicide apparatus to Mrs. Adkins' arm and stood by while she started a flow of poison into her body.

The second woman to whom Kevorkian provided his "services" was Sherry Miller, a 43-year-old woman who resided in Roseville, Michigan. Ms. Miller had multiple sclerosis, but was not terminally-ill and was not suffering physical pain. Dr. Ljubisa J. Dragovic, the Chief Medical Examiner for Oakland County, testified at the preliminary examination of Kevorkian (on charges arising from the deaths of Miller and Marjorie Wantz), that Miller was not in danger of imminent death as a result of multiple sclerosis, that the disease had not yet affected her heart, lungs, or gastrointestinal system, and that, considering the quality of her internal organs, "she had good chances of relatively long survival." (Tr. of February 15, 1992, 326-327; see App. 8-9) She had simply become tired of trying to cope with her diminishing physical ability, and, since she was single, did not want to burden others with her care.[5]

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[5] Sherry Miller testified at a proceeding in the Oakland County Circuit Court wherein the amicus sought (and ultimately obtained) an injunction against Kevorkian providing any assistance to individuals seeking to commit suicide. She repeatedly stated that she desired to commit suicide because she didn't want to be a burden to her family. For example, in response to questioning from Kevorkian's attorney concerning whether she felt she had a responsibility to her parents to remain alive, Ms. Miller responded: " . . . I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. [I'm] Forty-two years old. They're getting older. No, it's not fair." (Oakland County Circuit Court case no. 90-390963 AZ, Tr. of January 8, 1991, p 155 – see App. 7-8.) Subsequently, when asked by the prosecutor when she first

The third woman Kevorkian assisted was Marjorie Wantz, a 58-year-old woman from Sodus, Michigan. Mrs. Wantz claimed to have suffered great and unremitting vaginal pain for a period of years. She related this pain to what she claimed was botched surgery (as well as repeated attempts at corrective surgical intervention). At one point she was committed to a mental hospital because no physical source could be found to explain the pain of which she complained. Eventually she decided that she didn't want to live with this psycho-somatic pain any longer and she sought out Kevorkian. A complete autopsy following her death failed to show *any* physical cause for her pain. (Tr. of February 15, 1992, at 338-339; App. 9-10) Moreover, there was *no* question that Mrs. Wantz was *not* terminally-ill, even under the broadest possible definition of that term.

The vast majority of the 44 individuals Kevorkian has assisted to commit suicide were not terminally ill as that phrase is commonly understood – that is, persons having less than six months to live. Many of the people he assists to die continue to be individuals who appear to have simply decided they don't want to live anymore.[6] Two individuals have died after suffering from non-terminal emphysema. One woman had arthritis and osteoporosis. A recent patient/victim was depressed, overweight, and allegedly suffering from "chronic fatigue syndrome" and fibromyalgia. Prior to death she had made allegations of

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decided that she wanted to die, she answered: "That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time." (Tr. of January 8, 1991, *supra*, at 169; App. 8.)

[6] M. Betzold, *"Drop dead, Dr. K"*, The Detroit Sunday Journal, June 16, 1996, p 1, col. 3.

spousal abuse against her husband, allegations which she subsequently sought to disavow. If those allegations were true, they cast serious question on her reasons for seeking to end her life. If they were false, they cast serious question on her mental competence in seeking death.

Once again, it can be expected that supporters of assisted suicide will argue that simply imposing more safeguards, or checks and balances, can alleviate any of the concerns arising from Kevorkian's unregulated practices. Practical experience shows that such optimistic assessments must be rejected.

If a complex system of safeguards is to be set up to attempt to regulate assisted suicide, establishment of such a system is a job for state legislatures, not a judicial function. Moreover, once this Court pronounces a limited right to assisted suicide under certain conditions, it has cut off public debate and interfered with the ability of the states to legislate effectively.

Supporters of assisted suicide maintain that with sufficiently stringent criteria and proper monitoring, the State could ensure that only competent, terminally-ill adults would receive the "benefit" of physician assistance to end their lives. However, practical experience demonstrates that it is naive to believe that the practice of assisted suicide, once legitimated even in a limited form, could be successfully restricted or regulated.

Estimates seem to vary, but a clear majority of states currently outlaw assisted suicide. Yet the fact that it is criminally actionable in most states has not dissuaded numerous doctors and nurses from quietly practicing either assisted suicide or out-right euthanasia, as the writings and practice of Respondent Quill show. See generally, T. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* (1993). Some people therefore argue

that, since it's being done anyway, why not simply legalize it under strict regulations and thereby control it? However, given that assisted suicide and euthanasia are being conducted in secret despite criminal bans, why should anyone but the most starry-eyed optimist believe that legalizing the practice under detailed regulations would serve to *control* the practice?

In their article *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U Richmond L Rev 1 (1996), authors Daniel Callahan and Margot White respond to the assertion that establishing specific rules and codes of practice will serve to bring the practice into the open and to control it:

> * * * If it is truly the case that the present statutes forbidding euthanasia and PAS [physician-assisted suicide] are widely ignored by physicians, why should we expect new statutes to be taken with greater moral and legal seriousness? There is no available survey or other evidence to indicate that new laws will bring increased commitment to following the law. [*Id.* at 5.]

Kevorkian has written that he was inspired to action by his trip to the Netherlands to study their experience with assisted death. *Prescription: Medicide, supra*, at 189-192. The Dutch experience with legalized euthanasia demonstrates the futility of believing that legalizing the practice under strict controls could result in an orderly process applied only to those who met stringent guidelines. Once the government approves of the practice – even the very *limited* practice that some have advocated – there would simply be *no* way to contain it. It would be like saying that we could tolerate just a little bit of the Ebola virus in our bodies.

Dr. Richard Fenigsen, who has extensively studied the experience in the Netherlands, has written of the way in which the practice expands organically in spite of specific procedures which are mandated by the government. Fenigsen notes that the Dutch have one of the best and most comprehensive health care systems of any industrialized nations. Nevertheless, despite this comprehensive care system, "the lives of many people are deliberately put to an end, and this happens sometimes upon the request of the person in question and sometimes without his or her request, consent, or knowledge." R. Fenigsen, M.D., *Physician-Assisted Death in the Netherlands: Impact of Long-Term Care*, 11 Issues in Law & Medicine 283 (1995). Looking to data for the year 1990, Fenigsen reports that out of 13,506 lives ended by withdrawing or withholding medical treatment with the intent to terminate life, 8,750 (or 64.78%) occurred *without* the patient's consent. Similarly, out of 11,800 individuals whose lives were ended through active euthanasia, 5,941 (or 50.35%) occurred *without* the patient's consent. Fenigsen further notes:

> The Report of the Government Committee confirmed that the lives of newborn babies with disabilities and of gravely ill children are also terminated, but no exact figures pertaining to these groups were obtained. However, an estimate of euthanasia on newborn babies and infants up to three months after birth was published by the Royal Dutch Society of Medicine in 1988. Annually, three hundred babies disabled due to extreme prematurity, birth trauma, spina bifida, or Down syndrome are starved and dehydrated to death or denied lifesaving surgery; ten babies with disabilities receive lethal injections each year.

> A Committee of the Royal Dutch Society of Medicine stated that termination of life of a newborn is justified if the child almost certainly would have an unliveable life. * * * .
>
> There may be disagreements between the persons who decide, but if the doctor and the parents agree on euthanasia, the life of the child will be terminated.
>
> According to the Royal Society's Committee, when the life of a disabled newborn is terminated, this should be done by refraining from lifesaving medical interventions and depriving the child of food and water; only when this is done and the child does not die, a lethal injection is justified. Again, the practice in some cases departs from the official advice, and doctors proceed directly to administering the lethal injections. *Id.* at 285-286; footnotes omitted.

The experience Amicus has had with Kevorkian firmly supports the above observations. An example which perhaps best illustrates the naiveté of believing that strict regulations can prevent abuse is the case of Rebecca Lou Badger. Kevorkian allegedly assisted Badger to commit suicide on July 9, 1996. Badger had been diagnosed with multiple sclerosis. However, an autopsy revealed no evidence of the disease. Detroit Free Press, Oct. 31, 1996, at 1A , col. 1; see also, Detroit Free Press, Nov. 4, 1996, at 1B, col. 2. In interviews that Badger had with the Merced County [California] Sheriff's Department, she claimed that her mother was pressuring her to commit suicide and "had twice provided her with narcotics" for that purpose. *Id.* The October 31, 1996, Detroit Free Press article goes on to report at page 12A:

> Friends and relatives interviewed in recent weeks described Rebecca Badger as an unreliable woman who often lied. But whether or not

> her accusations against her mother are true, the events she described – some of which are confirmed by hospital records and police reports – reveal a disturbed and confused woman who vacillated between a desire to die and a fervent wish to live.

In response to such criticism, Kevorkian's attorney is reported to have responded to the Free Press reporter: "What's the point? I do not care if she thought Martians were coming after her." *Id.* Similarly, in an article titled "*Post Mortem*" in the September 16, 1996 issue of People Magazine at page 53, Kevorkian's attorney is reported to have asserted that Kevorkian merely relied on Badger's medical records when deciding that she was a suitable candidate for this service:

> "If they were wrong, then take the doctors' licenses away," [Geoffrey] Fieger fumes. "Don't criticize Jack. **He just accepted what they said**, and they said it repeatedly over the years." [*Id.* at 55; emphasis supplied.]

The article continues at page 55:

> • • • But the respected UCLA neurologist Dr. Louis Rosner, coauthor of the book *Multiple Sclerosis*, argues that since MS is often misdiagnosed, Kevorkian should have sought more opinions, "He accepts anything [patients] bring him as medical evidence," Rosner says, "and goes ahead with their wishes."

Badger's personal physician now says that she merely assumed Badger had MS because that was the diagnosis made by her neurologist. The neurologist now says that "his diagnosis was never conclusive" and that Badger could have suffered from Munchausen syndrome. Detroit Free Press, Nov. 4, 1996, *supra*, at 8B. It also appears that Badger was likely making continuing claims

of pain in an effort to obtain more pain relievers such as Vicodin, Demerol, and liquid morphine. *Id.*

According to the above article in People Magazine (and verified by a taped interview with Badger's daughter Christy Nichols, who was present when her mother died), Kevorkian's associate, Dr. Georges Reding interviewed Badger for between fifteen to thirty minutes immediately prior to the suicide itself to determine Badger's mental competence.[7] While Reding was conducting the *pro forma* interview, Kevorkian and his associate Neal Nicol were already setting up the apparatus and chemicals with which the deadly poisons would be introduced into Badger's body. See also Detroit Free Press, Nov. 4, 1996, *supra* at 8B.

Thus the case of Rebecca Badger tellingly reveals the way things will be if this Court recognizes a constitutional right to assisted suicide. Kevorkian followed the general outlines of the steps that most supporters of assisted suicide have argued would control the practice. He reviewed Badger's medical records. He interviewed Badger herself to determine if she was competent and if it

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[7] The involvement of Dr. Reding is clearly meant to stem criticism that has been leveled at Kevorkian based on the fact that he has no expertise in evaluating the mental status of his "patients." However, Dr. Reding is a vocal supporter of Kevorkian's campaign and cannot be expected to function as a neutral evaluator. As reported in the August 25, 1996, issue of the Dallas Morning News at p 1A, col. 1, Dr. Reding addressed a press gathering and stated: "I want to make sure that this word 'depression' is properly diagnosed and not mixed up with despair," Dr. Reding told the reporters. "People with a history of mental illness long before they become ill are one thing. But sick people despondent about their own suffering are another. In that case, their depression is rational and the antidote is not Prozac, but death."

was her considered choice to commit suicide. His associate, Dr. Reding, also interviewed Badger to assure that she was competent to make the decision to end her life. The key determination in their assessment was whether this was *her* considered choice. Since it was viewed from the perspective that the "patient's" right to personal autonomy was paramount, when Badger stated that she wanted to commit suicide, and she exhibited an objective basis grounded in her apparent medical condition for that decision, then Kevorkian and his associates merely acted to facilitate her assertion of her autonomous right.

Supporters generally speak in terms of *physician*-assisted suicide. Aside from the fact, as noted above, that this involves doctors in a realm that runs counter to their duty as healers, it elevates the practice of helping someone to kill themselves to a *medical procedure*. As Kevorkian's activities have clearly shown, assisting someone to kill themselves is *not* a medical procedure.[8]

Assisted suicide can be practiced in many forms. Kevorkian has utilized but two of the possible forms – carbon monoxide poisoning and injection of potassium chloride. The former can be administered by anyone – there is no need for a *doctor*.[9] Numerous *un*-assisted suicides occur each year from people who get into their cars in closed garages, start the engines, and drift off to death from carbon monoxide inhalation. Even injection of

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[8] In his testimony in the civil injunction case, Kevorkian acknowledged that his activities were not medically accepted and recognized procedures. Tr. of June 8, 1990, at 28; App. 1.

[9] Indeed, although still possessing a medical degree, Kevorkian's license to practice medicine has been suspended by both Michigan and California following his involvement in the Adkins death. This has not prevented him from continuing to assist others to commit suicide.

deadly drugs can be accomplished by other health professionals (such as nurses,[10] medical technologists, or physician assistants), by those who regularly self-inject medication (such as diabetics), or by virtually anyone who desires to study the technique and practice a little.

Furthermore, the right which doctors such as Respondent Timothy Quill have attempted to secure is the right to simply dispense oral prescription medicines to terminally-ill competent adults for them to utilize without active physician assistance to end their lives.[11] Such assistance may be provided by anyone licensed to dispense controlled substances. Once the right to die with assistance is recognized, how could it be limited to medical doctors when the procedure itself is not a medical procedure and no particular medical training is necessary in order to administer it?

Columnist Richard Cohen has written in his nationally-syndicated column (reprinted in the Detroit Free Press, June 30, 1996, at 3E, col. 1, *"Patient's can't tell their stories after their visits to Kevorkian"*):

> Why, I ask myself, can a woman be driven several hundred miles to see Dr. Jack Kevorkian but cannot be placed in the same car within her own closed garage and commit suicide within a step or two of her own home?
>
> The answer, I conclude, is not that the act of suicide is physically beyond her; it's rather that

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[10] See, D. Asch, M.D., *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New England J Med 1374 (1996), at pp 1374-1379 and C. Scanlon, R.N., *Euthanasia and Nursing Practice – Right Question, Wrong Answer*, 334 New England J Med 1401 (1996), at pp 1401-1402.

[11] In other words, an exception is sought with regard to stringent controls that are placed on a doctor's ability to prescribe and dispense controlled substances to the public.

she needs a facilitator. This is where Kevorkian comes in. The road to his clinic is a one-way street.

Kevorkian is a retired pathologist whose training and experience consists largely of examining corpses rather than in counseling live patients. He has no formal expertise in psychiatry or psychology. (Testimony of Jack Kevorkian, Tr. of June 8, 1990, 41-42; App. 2-3) Although he claims in his writings that he consulted with the personal physicians of his subjects, he sought no independent second opinions. In fact, he frequently ignored the opinions of those medical professionals who had been counseling, treating, or assisting the decedents.[12] He also ignored the physical evidence in front of him.[13]

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[12] As Kevorkian writes in *Prescription: Medicide*, *supra* at 222:

> I then telephoned Janet's [Adkins'] doctor in Seattle. He opposed her planned action and the concept of assisted suicide in general. **It was his firm opinion that Janet would remain mentally competent for at least one year (but from Ron's [Janet's husband's] narrative I concluded that her doctor's opinion was wrong and that time was of the essence).** Because Janet's condition was deteriorating and there was nothing else that might help arrest it, I decided to accept her as the first candidate – a qualified, justifiable candidate if not "ideal" – and well aware of the vulnerability to criticism of picayune and overly emotional critics. [Emphasis supplied.]

[13] In an op-ed column (W. Smith, *Depressed? Don't Go See Dr. Kevorkian*, N. Y. Times, Sept. 16, 1995, at § 1, p. 19, col. 2), Wesley J. Smith quotes Dr. Randolph B. Schiffer, an advisor to the National Multiple Sclerosis Society, as follows:

Kevorkian is answerable only to himself. Not only does he ignore the law, he taunts and belittles those who would enforce it against him. The Michigan Court of Appeals and the Michigan Supreme Court have upheld both a temporary state statute forbidding assistance in a suicide and the continued validity of the State's common-law prohibition against assisting a suicide. *People v Kevorkian*, 447 Mich. 436; 527 N.W.2d 714 (1994), cert. den. ___ U.S. ___; 115 S. Ct. 1795; 131 L. Ed. 2d 723 (1995); *People v Kevorkian No 1*, 205 Mich. App. 180; 534 N.W.2d 172 (1994). Nevertheless, Kevorkian has not only convinced three juries to ignore the law,[14] he has continued

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> "If a patient with multiple sclerosis has bed sores, it means by definition that, for whatever reason, he or she is not receiving adequate medical care."

Smith goes on to observe:

> Last month, Esther Cohan, who was 46 years old, committed suicide with the help of Jack Kevorkian. Ms. Cohan, who had multiple sclerosis, was disabled but not terminally ill. Esther's sister told reporters that her sister's body was covered with bed sores. Yet, according to Jack Kevorkian's lawyer, Geoffrey Feiger, Dr. Kevorkian had been "counseling" Ms. Cohan since March. Didn't he know that he was participating in the suicide of someone who, by Dr. Schiffer's standards, appears to have received inadequate care?

[14] Professor Yale Kamisar of the University of Michigan has noted the increased incidence of jury nullification associated with cases involving "mercy killing" in the 1940's and 1950's. Y. Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 Minn L Rev 969, 971-973 (1958). His observations have been proven to apply equally to physician-assisted suicide. Kevorkian has been tried three times (once in Wayne County, Michigan, and twice in Oakland County, Michigan, involving a total of five patients/victims) and has

to violate the law and publicly boast of his transgressions.

Practical legal problems beyond the specter of jury nullification have already arisen in this area, as the experience of amicus has shown. Kevorkian initially announced his participation in the assisted suicides of his "patients." He would personally alert the police to the deaths. He was present when the police arrived and made statements to them. Evidence associated with the administration of the poisons (i.e., intravenous solutions, tubing, needles, carbon monoxide canisters, regulators, tubing, masks) was still present at the scene. Subsequently, when criminal charges were filed, he changed his practice. First, he would still contact the police, but when they arrived at the location of the suicide (often his Royal Oak apartment), the evidence associated with the suicide would have been removed. While he would make no statements to the police, his attorneys would subsequently call press conferences to announce Kevorkian's "attendance" at a suicide and to give details (often incorrect) of the deceased's medical background. Lately, Kevorkian has taken to simply dropping the body off at the medical examiner's office or at a local hospital, providing a few sketchy personal details about the deceased, and then leaving.

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been acquitted by the juries in each case. In each case there was clear and abundant evidence that Kevorkian actively assisted the decedents to commit suicide by providing the poison and the poison-dispensing apparatus and by hooking the decedents up to the apparatus. The defense did not dispute that he had done so. Nevertheless, in each instance the jury has seen fit to respond to Kevorkian's claim that he did not intend that the decedents should die, but rather that he only wished to relieve their pain and suffering.

Thus, Kevorkian continues to ignore the law while making it practically impossible to investigate or prosecute him. Since no one outside the immediate circle of participants knows for certain where the deaths occur, venue is difficult to establish.[15] Since the bodies are dropped off at the medical examiner's office or at hospitals, none of the paraphernalia associated with the "suicide" can be examined or seized. Those who are present at the death are either not identified, or, if their names are mentioned at a Kevorkian press conference, they refuse to cooperate with investigations by law enforcement.[16] In

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[15] Kevorkian's flamboyant attorney used this fact as a legal stratagem in a case tried in Wayne County. The body of Thomas W. Hyde, Jr. was found in Defendant's battered VW bus on Belle Isle, an island park in the Detroit River located in Wayne County. At trial, Kevorkian's attorney insisted that the death itself had actually occurred in Royal Oak – Oakland County, Michigan – and argued to the jury that they couldn't convict because venue (a necessary element) hadn't been established in Wayne County.

[16] An article appearing in the September 20, 1996 edition of the Detroit Free Press described how evidence obtained when police interrupted a Kevorkian "consultation" appeared to indicate that Kevorkian had assisted a 54-year-old Ionia, Michigan, woman who had multiple sclerosis to commit suicide. According to the article, a videotape seized by police depicts Kevorkian telling "an Ionia man how to mislead authorities about the cause of his wife's death". When questioned about this, Kevorkian's attorney responded: "I would urge all the families involved to tell the police that their loved ones went to Disneyland and fell off the mouse ride." A family physician had filled out the death certificate and attributed the death to natural causes resulting from multiple sclerosis. The body was then cremated. However, evidence of the woman's pre-death condition clearly suggested that she was not in a terminal condition. Detroit Free Press, Sept. 20, 1996, at 1A, col 2. Kevorkian's attorney has announced that there are others in

fact, when the police have subsequently contacted these individuals, they have refused to cooperate and referred the police to Kevorkian's attorney. The police and prosecutors have no way of compelling those witnesses to give information if they do not want to cooperate. Kevorkian's attorneys have routinely claimed to represent all the witnesses and have asserted their Fifth Amendment right not to incriminate themselves. Thus the public is left only with the self-serving statements of Kevorkian's attorneys describing what has occurred and the medical condition of the patient before his or her death.

Another legal obstacle to any effective regulation of assisted suicide is the venerated legal principle that mere presence at the scene of the crime is not itself a crime. *People v Burrel*, 253 Mich. 321, 323; 235 N.W. 170 (1931). That is why Kevorkian can stand in front of television cameras and state with impunity, "I was present at another assisted suicide." In that way Kevorkian takes credit for thumbing his nose at the law with no real risk to himself. Moreover, any comments his attorney makes cannot be used as evidence against Kevorkian.

If a right to physician-assisted suicide is recognized, regardless of how limited the right or how carefully we craft guidelines to prevent abuses, experience shows us there is no effective way to insure compliance with those guidelines and guarantee that significant abuses will not occur.

Michigan who have received Kevorkian's assistance in ending their lives, but whose names have not been, and will not be, released. *Id.* at 8A, col. 1 and Detroit Free Press, Sept. 12, 1996, 8B, col 1. On November 4, 1996, Kevorkian finally admitted that he had been present in Ionia at the death of Loretta Peabody. Detroit Free Press, Nov. 5, 1996, 1B, col. 2.

Police investigations into suspicious cases will be hindered by invocation of the physician-patient privilege.[17] The physician and patient's family control all of the information. Assisted suicide, by its nature, is a private matter between physician and patient. Decisions about suicide are made in private and the action itself is taken in private. Since we cannot place a police officer in every doctor's office, there is no practical way of knowing what the doctor and patient are going to do or what they have done. After death there is no practical way to determine whether the decision to commit suicide was voluntarily made, without subtle pressure or manipulation. A "conspiracy of silence" will develop since the "patient" will be dead and the physician will be able to invoke the privilege as a means of avoiding any questioning. Callahan and White, *supra*, at 8.

Furthermore, the physician-patient privilege would prevent law enforcement personnel from knowing the patient's plans for death or from obtaining medical records to determine the true medical condition of the patient. The physician-patient privilege continues after death and thus, even after the suicide has occurred, there is no way in which the truth of the suicide's condition can be determined. Practical experience in Michigan has

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[17] While acknowledging in his in-court testimony on June 8, 1990, that his use of the "suicide machine" with Janet Adkins was not a medically recognized and accepted procedure [Tr. of June 8, 1990, at p 28; App. 1], he claimed in his deposition testimony that his interview with Adkins was privileged because it was a medical consultation between a patient and her physician. [Tr. of July 25, 1990, at 8-9; App. 4-5.] Kevorkian's attorneys subsequently raised the physician-patient privilege as a barrier to turning over routine discovery during Kevorkian's criminal trials.

shown that this concern is very justified. As noted, Kevorkian has counseled "patients" and their families and friends to decline to cooperate with police investigations. See fn 16, *supra*. He has also apparently participated in one or more assisted suicides which have been covered up.

And what of the mental competency of the individuals who have surrendered themselves to Kevorkian's "tender ministrations"? Case law recognizes that one of the main reasons suicide itself was de-criminalized is that people who desired to commit suicide were generally considered to be mentally disturbed. T. Marzen, M. O'Dowd, D. Crone, & T. Balch, *Suicide: A Constitutional Right?*, 21 Duquesne L Rev 1, 63, 69 and n 467, 85-86, 88-89 (1985); *In re Joseph G*, 34 Cal. 3d 429, 433; 667 P.2d 1176; 194 Cal. Rptr. 163 (1983). As noted previously, Kevorkian's second "patient", Marjorie Wantz, had previously been committed to a mental hospital. Judith Curren was despondent over her weight, her "chronic fatigue syndrome", and, perhaps, her marital situation. Rebecca Badger had a history of alcoholism, an apparent addiction to pain medication, vacillated on the question of whether she wanted to die or whether she was being pressured to do so by her mother, and is now said by her neurologist to have possibly suffered from Munchausen's syndrome. Kevorkian's response is that the mental condition is irrelevant as long as the "patient" has some physical malady and knowingly requests his assistance to die. Tr. of June 8, 1990, at 40, 44-45; App. 3-4.

More significantly with respect to most potential "patients," however, is the fact that studies have shown that most individuals who express interest in committing suicide are suffering from depression – often arising out

of their condition or the absence of a support system – and that when the depression is treated, the desire to commit suicide disappears. See, *e.g.*, Report of the New York State Task Force On Life And The Law, Executive Summary, p x.[18]

In an article titled, *"Mock Medicine, Mock Law"* in the June/July 1996 issue of the journal First Things, Dr. Eric M. Chevlen, the Director of Palliative Care at St. Elizabeth Health Center in Youngstown, Ohio, (and a prosecution witness in both of the Oakland County criminal trials) has written of watching a Kevorkian-produced videotape of an interview with a "patient":

> The videotape seemed to be filmed in a cheap hotel room. It showed a man with advanced myeloma (bone cancer) asking for assistance in suicide. He appeared to be a textbook example of depression in the face of medical illness and inadequately treated pain: the flat voice, the lack of eye contact, the moving description of how life no longer yielded any pleasure, and even the veiled contempt he expressed for his own disability. I have seen many such patients in my career. In every case, the request for suicide was a symptom of depression, a treatable complication of cancer. In every case, proper treatment of the patient's pain, accompanied by emotional support and occasionally antidepressants resulted in reversal

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[18] The Report summarizes: "Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide."

of the wish to be killed. As I watched the interview, I felt like shouting at the eerily jovial "doctor" on the screen, "He's depressed, you idiot! Treat him, don't kill him!"

But of course I knew that only a few hours after the videotape was made the myeloma patient had joined the long list of those who had died "in the presence of" Jack Kevorkian.

The encounter between Kevorkian and his victim was a simulacrum of a genuine medical interview. When Kevorkian asked the victim whether or not he had been experiencing pain, it was not with the intent to find a better medicine to treat it. It was to justify the use of the carbon monoxide he had obtained even before meeting him. When Kevorkian asked about the victim's anguish and wish to die, it was not to assess or relieve the obvious depression. It was to document that his "assistance" was given only with the victim's consent. [*Id.* at 17.]

Additionally, in light of the delays that have occurred while the issue of assisted suicide was appealed in the Michigan courts, in light of the successful public relations campaign Kevorkian has conducted, in light of the inability of law enforcement to either stop the practice, issue charges in pending open investigations, or to secure convictions following three separate trials, public opinion and blatant defense appeals to jury nullification have made it increasingly difficult or impossible to obtain a jury that will follow the law.

In fact, given that judges in Michigan are elected, it is not surprising that many judges facing re-election (and with an eye on the public opinion polls) find it difficult to divorce their personal opinions on the issue from their legal duty to follow the law. This reality will work to discourage active investigation by the police or serious

efforts to prosecute by the local prosecutors. Already the candidates for Oakland County Prosecutor from both political parties have publicly indicated that they will not prosecute Kevorkian under the Michigan common-law prohibition recognized by the Michigan Supreme Court, and have further indicated reluctance to institute any prosecutions even if the Michigan Legislature enacts a specific statutory prohibition.

In *Legalization of Physician-Assisted Suicide, supra,* at 5-6, Callahan and White observe:

> * * * Nor are there any surveys or other available evidence to suggest that prosecutors will show more zeal with new laws than with the old ones, or that juries will display less sympathy for violation of the new rules than they have for those who transgressed the old rules. It is, in short, very odd to claim that physicians who now do as they please, with complete de facto immunity from prosecution, will act differently with new laws, and that the new laws will be more stringently enforced. [Footnote omitted.]

A strong and clear judicial response that unequivocally states that the Constitution does not contain a right to assisted suicide would go far toward influencing public attitudes and putting the lie to the claim voiced by Kevorkian and his supporters that he is only doing that which is protected by the Constitution. It would alleviate the confusion which has arisen as a result of the conflict between the decisions of the Ninth and Second Circuits striking down bans on assisted suicide and the decisions of state courts which have upheld such bans. It would also place this serious and troubling issue into the proper forum – the state legislatures where the people's elected representatives can debate and grapple with a solution, or the ballot initiative alternative where the people can

directly vote on the issue. It is only by refusing to recognize a new and uncontrollable constitutional right to have the assistance of another person to commit suicide that this Honorable Court can ultimately protect the rights of those who would inevitably become victims of the seductive "right to die."

CONCLUSION

WHEREFORE, Amicus Richard Thompson, Prosecuting Attorney in and for the County of Oakland, respectfully requests this Honorable Court to reverse the decisions of the Ninth and Second Circuits in *Washington v Glucksberg*, 79 F.3d 709 (CA 9, 1996) and *Vacco v Quill*, 80 F.3d 716 (CA 2, 1996).

Respectfully submitted,

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Date: November 11, 1996

APPENDIX

Excerpts from testimony of Jack Kevorkian in Oakland County Circuit Court in case no. 90-390963 AZ, June 8, 1990

Page 28:

Q [By Ass't Prosecutor] Doctor, would you say your use of the machine with Janet Adkins was in fact a medically accepted and recognized procedure?

A [By Jack Kevorkian] Not at all.

Q You in fact admit that it is not?

A It is not an acceptable practice; that's obvious.

Pages 40-41:

Q [By Ass't Prosecutor] And yet you're saying that you have to decide whether someone is worthy of your machine or not, so –

A Based on my medical expertise, not morality. My morality doesn't enter this. You don't know what my morality is. You haven't asked me that. But my medical expertise is the basis. There are five – may I go on with this and explain it briefly? There are five – I've come to this conclusion. I must – understand that it's not egotistical when I say, "I've done this, I've done that." Nobody helps me. I've got to do it. There are five criteria. Two with the patient: the patient's needs and the patient's wishes. Two. You take these into consideration. From the doctor: His medical expertise; his common sense; and his logic. Three. Now, these last

two are lacking in many doctors. Common sense and logic. The expertise he has. Everyone has that. We know that. They're pretty much equal.

Now, a good doctor would put these all together, and his expertise is the cardinal point. That's why ethicists don't belong in this decision. The doctor can philosophize as well as any theologian can, but a theologian can't know medicine like a doctor. It takes training and experience.

So, based on these five criteria – I wish it could be a group of doctors pooling this, without any extraneous ethicists – he comes to a decision with the cardinal point being medical expertise. Is the patient's wish and desire worthy of having this option granted?

Pages 41-42:

THE COURT: Excuse me, Doctor, but what is you medical expertise?

THE WITNESS [Jack Kevorkian]: Mine is limited, and that's why I say I want to pool, but they won't come forward –

THE COURT: No, no –

THE WITNESS: A pathologist, certified pathologist.

THE COURT: Are you licensed to practice pathology –

THE WITNESS: Licensed in Michigan and California – in California and Michigan, licensed to practice, yes, your Honor.

THE COURT: Do you have any other licensures in some –

THE WITNESS: No, just those two states.

THE COURT: Just those two states, both for pathology only.

THE WITNESS: No, for medical doctor. I could open an office if I want. I could help with surgery. I could treat any disease I want. Medical licensure allows one to do anything in medicine.

THE COURT: But you said expertise. Are you –

THE WITNESS: My specialty expertise is pathology, right.

Pages 43-44:

Q [By Ass't Prosecutor] Well, Doctor, don't you think that suicidal ideation would be an important thing that you would have to know before you deal with people who are asking to be put to death?

A Not if they have a crippling physical disease. Suicidal ideation is a mental problem. I don't rely on mental problems. I rely on their physical disease, which then affects their mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal.

Pages 44-45:

Q [By Ass't Prosecutor] Doctor, so in other words, you really don't care what the person's mental state is, if they in fact have a crippling disease and they say they want to die?

A Well, of course, I care. But the cardinal point is the physical disease. Is a physical disease enough to account for the mental state of the

patient? I said it's a grey zone. But in the case of David Rivlin last year, everybody who saw him said he should die, except a couple of religious fanatics. Now, would it take a great amount of medical expertise to decide that? If nothing else, establish this policy for that kind of case where everybody who looks at it says, "Yes." Even if it doesn't take a doctor.

Excerpts from Deposition of Jack Kevorkian in Oakland County Circuit Court case no. 90-390963 AZ, July 25, 1990

Pages 7-9

Q [By Ass't Prosecutor] As I understand it, when the state police officers contacted you as to being able to see a videotape they understood was available with your meeting of Mrs. Adkins on June 2nd –

A [By Jack Kevorkian] Uh-huh.

Q – you indicated you would not let them see it. Is that correct?

A That's true.

Q And you indicated there was going to be certain ground rules as to who could see that tape?

A Yes, but I didn't spell out the ground rules in detail.

Q Weren't they, in fact, the same ground rules that were in line with the consent to videotape that Janet Adkins prepared?

A That was part of it.

Q So, in other words, in this form where it states, (Reading) " . . . that said videotape or

motion picture be made available on a non-profit basis for viewing only by professional medical personnel, legislators, and judicial and other duly empowered authorities directly concerned with the promulgation and creation of the laws, rules, regulations, and ethical guidelines in connection with doctor-assisted suicide, with active euthanasia, or with judicial execution involving some kind of direct medical action and/or pharmaceutical drug."

Are you saying there were others?

A Yes, at that time I should have, I should have remembered – this was a medical consultation. It's privileged.

Q I'm sorry, where does it say that?

A It should have said that. That's an oversight.

Q And it doesn't say that?

A That's right.

Q If you're going –

A I realized later it's medical privilege between a patient and doctor.

Q When did you realize that?

A Later.

Q When's later.

A I cannot recall, but it was after this.

Page 13:

Q [By Ass't Prosecutor] Okay. And at this point in time had you, in fact, been retained as her doctor?

A [By Jack Kevorkian] When she contacted me I was retained as her doctor, yes.

Q When did they contact you?

A Her husband actually contacted me for her and she, I assume, she became my patient when I met her on June two.

Q That's the first time you had any contact with her?

A That's the first time I had direct contact with her personally.

Page 18:

Q [By Ass't Prosecutor] Okay. How long was the videotape?

A [By Jack Kevorkian] It's about 40 minutes.

Q And how was it finally concluded?

A I had come, I concluded that there was enough evidence that she was mentally sound. She knew what she was doing.

Pages 24-25

Q [By Ass't Prosecutor] At the time prior to the videotaping, did you physically examine Janet Adkins?

A [By Jack Kevorkian] No.

Q Did you take her heart rate?

A No.

Q Listened to her heart?

A No.

Q Did you even bring a stethoscope?

A No.

Q No physical evaluation at all?

A No.

Q Why is that?

A Her doctors had done all that. I had the records. Also it's a mental disease, not physical.

Q The records, as I understand it, were from the previous year; isn't that correct?

A It's a mental disease, not physical. You all know it's not physical. It's an attack that's being used for a criticism of what I did.

Page 27:

Q [By Ass't Prosecutor] What if she was suffering from depression?

A Not to be depressed with Alzheimer's is abnormal.

Q Okay. The fact that a depression might have caused her to want to possibly commit suicide, wouldn't matter to you?

A A person can be rational and depressed and can make a rational decision.

Excerpts from testimony of Sherry Miller in Oakland County Circuit Court, case no. 90-390963 AZ, January 8, 1991

Page 155:

Q [By Kevorkian's attorney] Don't you have a responsibility to your parents to allow them to continue to take care of you?

A [By Sherry Miller] No, I'm going to say – yeah, I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. Forty-two years old. They're getting older. No, it's not fair.

Page 169:

Q [By Ass't Prosecutor] Now, when is it that you first decided that you wanted to die?

A That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time.

Excerpts from preliminary examination testimony of Dr. Ljubisa J. Dragovic in 52/3 District Court, case no. 92-115190 FC, February 15, 1992

Pages 326-327:

Q [By Ass't Prosecutor] Okay. Was Sherry Miller in danger of imminent death as a result of this multiple sclerosis?

A [By Dr. Dragovic] No.

Q Had it had any effect on her heart?

A No.

Q Her lungs?

A No.

Q Her gastrointestinal system?

A No.

Q Given the fact of her physical condition, and the condition of her heart and lungs and the

rest of her body, could you project a period of time where she would continue to live and not be in danger of death?

A That's for the Almighty to decide, really, in every one of us. But based on the evidence that was present, the examination of – her internal examination – there was no suggestion that she was in any acute phase of the disease that would have threatened her life in a matter of days or even weeks, for that matter.

For comparison – and it might sound parodoxical, she was talking about whether she was quote/unquote, terminal, she was no more terminal than, let's say Magic Johnson.

Pages 338-339:

Q [By Ass't Prosecutor] Did you examine the tissue to where would there be any sort of unremitting pain for Mrs. Wantz?

A [By Dr. Dragovic] I did not find any anatomical evidence that would have suggested itself as a source of pain there, in the genito urinary system, nor in the gastro intestinal system, for that matter.

Q Did you take any further steps to determine any source of pain there?

A All that I examined, including the sacral dorsal root ganglia that I removed together with the spinal cord, did not show evidence of structural abnormality.

Q If there's no structural source for the pain, and a person was feeling pain, Doctor, where would that pain be coming from?

A Without evidence of source of pain in that area, then pain would be generally central in character and origin.

Q What is central pain, please?

A Central pain means arising in the central nervous system, arising in the cortex of the central nervous system.

Q What does that mean in layman's terms?

A Layman's terms, would be – it would be pain coming from someone's head, not pain coming from a particular organ.

Q Is that a common phenomena?

A It's not unheard of in people that have this kind of problem.

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NO. 96-110

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October Term, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.
and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE, BRIEF OF SCHILLER INSTITUTE IN SUPPORT OF PETITIONERS, AND APPENDIX

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50 pp

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On Writ of Certiorari
to the United States Court of Appeals
for the Second Circuit

MOTION OF SCHILLER INSTITUTE FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, the Schiller Institute respectfully moves for leave to file the accompanying brief amicus curiae in the above-captioned case.

The Schiller Institute, founded in May 1984, has national organizations in the United States of America, Canada, most of the nations of Europe, Ibero-America, Australia, Thailand, India, and Japan.

The Schiller Institute has a deep and abiding interest in the principles and spirit of the American Revolution as an inspiration for all people, including elected officials and jurists in the United States, and urges them to reaffirm the Federal Constitution's dedication to the preservation and extension of the lives of its population, thus leading the rest of humanity on such a course.

Because of the Schiller Institute's past activities and its cultural optimism, its brief will bring to this case a perspective not currently before the Court. The accompanying proposed brief advances an argument not developed by Petitioners: the extent to which allowing physician-assisted suicide on any of the alleged grounds, or permitting the various states to do as they please, would be an act of world-wide negative significance. It would expose all those physicians acting in reliance upon such rulings to be adjudged criminally responsible for crimes against humanity in future proceedings similar to those had under the Four Power Agreement establishing the international tribunals at Nuremberg at the conclusion of World War II.

The Schiller Institute's brief supports the position of Petitioners and points out where such Nazi policies have led in the past and where they will lead again. It is the writer's expectation that this amici brief alone will address this issue directly and for that reason urges this brief be accepted.

The counsels for either party have not consented to the amicus curiae brief of the Schiller Institute.

For the above reasons, the Schiller Institute moves this Court to grant leave to file the accompanying brief amicus curiae in support of Petitioners.

Respectfully submitted,

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Dated: November 6, 1996

QUESTION PRESENTED

Amici Curiae will address the following question:

Whether judicially according a terminally ill, competent individual a constitutionally protected right to obtain the assistance of a physician to commit suicide will lead to punishable acts under future Nuremberg type tribunals established to punish those who commit such acts as being crimes against humanity.

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BRIEF OF SCHILLER INSTITUTE AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

Helga Zepp-LaRouche, the founder of the Schiller Institute, and chairman of its Board of Directors in the United States, chose the German poet of freedom, Friedrich Schiller, as the namesake for the Institute, because his belief in the beauty and power of human reason provides a strong and clear antidote

to the "cultural pessimism" which led to fascist economic and social measures.

The Institute currently has chapters throughout Eastern and Western Europe, Asia, Ibero-America, the Middle East, and Australia. Its internationai scope provides a constant reminder of the importance of decisions taken in the United States for the rest of the world. This perspective is particularly important in matters of the right to life, such as the one placed before the Supreme Court in Vacco v. Quill and State of Washington v. Glucksberg, et al. It is the Institute's belief that if the Supreme Court were to uphold assisted suicide, it would put the United States on a course which threatens the very existence of many Third World nations, as well as whole classes of individuals considered "useless eaters" in the United States itself.

At a major conference in November 1984, the Institute adopted a "Declaration of the Inalienable Rights of Man," modeled on the U.S. Declaration of Independence, but adapted with reference to the tyranny that has been established by the international financial institutions. Prominent among these rights, of course, were the rights to "life, freedom, material conditions worthy of man, and the right to develop fully all potentialities of their intellect and their souls." These rights would clearly be threatened should the U.S. Supreme Court decide in favor of "physician-assisted suicide."

Mrs. LaRouche, a German citizen, has shown a special interest in analyzing the dangers of the resurgence of Nazism and fascism today, and the Institute has joined her efforts. In a 1984 book called The Hitler Book, published by the Schiller Institute, she analyzed the philosophical roots of fascism, and pointed to the philosophies of irrationalism, and a wide-range of attacks against the Judeo-Christian humanist concept of man being created in the image of God, as constituting a growing threat to mankind. She attacked the Social Darwinists, and such

theorists as Colorado Governor Richard Lamm, as exemplary of this thinking today.

In a series of other books and conferences, the Schiller Institute has promoted economic development plans, space colonization, and classical culture as means to overcome cultural pessimism and solve the problems of economic devolution that mankind faces. These conferences have generally featured the economic theories and programs of Mrs. LaRouche's husband, economist Lyndon LaRouche, and have attracted considerable support, particularly within nations under the thumb of International Monetary Fund conditionalities.

The Schiller Institute and Mrs. LaRouche have often pointed to the standard of the Nuremberg Military Tribunal, which tried the Nazis for crimes against humanity after World War II, in contrast to the rapidly decreasing valuation on individual human life that has been evident over the last 20 years in particular. A close study of this standard shows that, at the bar of civilization -- as Justice Robert Jackson would say -- the trend of judicial decisions, and medical practice have been rapidly converging on the "ethics" of the Nazis and their Nazi doctors. Dr. Leo Alexander, who was the chief medical witness to the Nuremberg war crimes trial, forcefully reiterated that point to the Schiller Institute on several occasions. Dr. Alexander, who wrote the Nuremberg Code that established the moral, ethical, and legal principles defining crimes against humanity, emphasized that the acceleration of the tendency nowadays to accept euthanasia, this time in the form of the right-to-die movement, "parallels what occurred in Nazi Germany."

In November 1985, the Institute held a commemoration of the Nuremberg Tribunal in that German city, and announced the formation of a new commission to investigate crimes against humanity, dedicated to founding a new Nuremberg Tribunal.

Among the areas identified for investigation was "the euthanasia campaign in the industrialized countries, modeled on the 'mercy killing' campaign of the Nazis, which is targetting the old and sick people. What started with a campaign for the dubious 'right to die' has long since become a campaign for the 'duty to die' (Colorado Governor Lamm) for the old and sick, whose medical treatment is considered not 'cost effective.'"

Since 1985, the decline down the slippery slope of viewing more and more lives as "not worthy to be lived," has been dramatic. If the U.S. Supreme Court does not stop this descent, the U.S. role at Nuremberg will essentially be reversed.

REASONS FOR REVERSING THE COURT OF APPEALS

The Supreme Court should reverse the Court of Appeals on grounds that there is no constitutionally protected right to suicide. To judicially accord a terminally ill, competent individual, a constitutional right to the assistance of a physician to commit suicide will lead to punishable acts under future Nuremberg type tribunals established to punish those who commit such crimes against humanity.

BACKGROUND - PHYSICIAN-ASSISTED SUICIDE: THE GERMAN EXPERIENCE

The New England Journal of Medicine, Vol. 241: 39-47 of July 14, 1949 published "Medical Science Under Dictatorship" by Leo Alexander, M.D. Born in Vienna, graduating from its university in 1929, he came to America and became a medical investigator for Secretary of War Robert P. Patterson and a consultant to the U.S. Chief of Counsel at Nuremberg. As a psychiatrist and neurologist, Dr. Alexander became chief medical witness at the Nuremberg trials and showed that crimes against humanity can occur at any time, in

any nation, as the outcome of putting Hegelian "rational utility" above Judeo-Christian morality.

In his article, he recounts that a preparatory propaganda barrage was commenced even before the Nazis openly took charge. It was directed against the traditional compassionate 19th century attitudes toward the chronically ill. He points out that sterilization and euthanasia were discussed at a meeting of Bavarian psychiatrists in 1931. By 1936, extermination of the physically or socially unfit was so openly accepted, that its practice was mentioned incidentally in an article published in an official German medical journal.

Dr. Alexander describes in his article motion pictures dealing with euthanasia, including one depicting a woman suffering from multiple sclerosis, with her husband, a doctor, finally killing her to the accompaniment of soft piano music rendered by a sympathetic colleague in an adjoining room. He describes indoctrination in which high school mathematics books included problems stating the cost of caring for and rehabilitating the chronically sick and crippled. Math problems asked how many new housing units and how many marriage allowance loans could be given to newly wedded couples for the amount of money it cost the state to care for "the crippled, the criminal, and the insane."

The first direct order for euthanasia was issued by Hitler, dated September 1, 1939. Dr. Karl Brandt headed the medical section in charge. All state institutions were required to report on patients who had been ill five years or more and who were unable to work. Decisions to kill were made by experts, most of whom were professors of psychiatry in the key universities and who never saw the patients. Decisions were based on questionnaires giving name, race, marital status, nationality, next-of-kin, whether regularly visited and by whom, who bore financial responsibility, et cetera. One expert

consultant between November 14 and December 1, 1940 evaluated 2,109 questionnaires. The semantics in vogue then prompted the name of this program to be "Realm's Work Committee of Institutions for Cure and Care." A parallel organization devoted to killing children was called "Realm's Committee for Scientific Approach to Severe Illness Due to Heredity and Constitution." The "Charitable Transport Company for the Sick" transported the patients to the killing centers. The "Charitable Foundation for Institutional Care" was in charge of collecting the cost of the killings from the relatives, without, however, informing them what the charges were for. The cause of death was falsified on the death certificates.

Dr. Alexander quoted verbatim what a member of the court of appeals at Frankfurt-am-Main wrote in December 1939 of constant discussion of the destruction of the socially unfit, and that abnormal activity was taking place. The judge said people were:

> ... disquieted by the question of whether old folk who have worked hard all their lives and may merely have come into their dotage were also to be liquidated.... The people are said to be waiting for legislative regulation providing some orderly method that will ensure especially that the aged feeble-minded are not included in the program.

Dr. Alexander described the early warning signs in the changes in medical attitudes:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic

attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that <u>there is such a thing as life not worthy to be lived.</u> This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick.

It is, therefore, the subtle shift in emphasis of the physicians' attitude that one must thoroughly investigate. It is a recent significant trend in medicine, including psychiatry, to regard prevention as more important than cure. Observation and recognition of early signs and symptoms have become the basis for prevention of further advance of disease.

In looking for these early signs one may well retrace the early steps of propaganda on the part of the Nazis in Germany as well as in the countries that they overran and in which they attempted to gain supporters by means of indoctrination, seduction and propaganda.

(Emphasis added)

BACKGROUND - NUREMBERG TRIBUNAL: THE CASE OF DR. KARL BRANDT

It was America alone who brought the Nazi doctors to trial. The U.S. Tribunal made clear that the crime of euthanasia was so abhorrent to the civilized world, that the U.S. had to prosecute it. The U.S. military constituted special tribunals to try the doctors for euthanasia, and made it clear from the outset that these particular men were on trial, not for having murdered Jews and Gypsies, not for having murdered Poles -- they had not, others had -- but for having murdered Germans. Furthermore, the murdered Germans have no one to speak for them, since they had been murdered at the hands of their own government.[1]

Prior to Hitler's formal euthanasia order of October 1939, back dated to September 1, 1939, the day of the invasion of Poland, each case of "mercy killing" was decided by Hitler in response to letters from parents and doctors asking for his approval to "grant" a euthanasia death to retarded or disabled children. The first such request came in 1938, from a couple named Knauer, whose infant was born blind, with a leg and part of an arm missing, and "who seems to be an idiot." Hitler had his own physician, Karl Brandt, consult with the child's doctors and parents; then he gave his permission for the child to be killed.

In 1973, the father of the child described Brandt's discussion with him: "He explained to me that ... the Fuehrer

[1] Molly Hammett Kronberg, Hitler's Euthanasia Program--More Like Today's Than You Might Imagine, from "How to Stop the Resurgence of Nazi Euthanasia Today; including Transcripts of the International Club of Life Conference, Munich, West Germany, June 11-12, 1988," EIR Special Report, pp. 129-142 (Sept. 1988).

wanted to [solve] the problems of people who had no future -- whose lives were worthless." Knauer said Hitler was "like a savior to us -- the man who could deliver us from a heavy burden."[2]

After the Knauer child's case, Hitler ordered the Reichschancery Secretariat and Brandt to investigate each new case, and to make recommendations.

The lives of such unfortunates, Hitler told his intimates, "are not worth living." He continued, these people deserve "mercy -- in their case, death."

In the summer of 1939, Hitler called in his Secretary for Health in the Interior Ministry, and Reichschancery Secretary Lammers to tell them that, "He considered it to be proper that the 'life unworthy of life' of severely mentally ill persons be eliminated by actions that bring about death." In this way, Hitler said, "a certain cost-saving in hospital, doctors, and nursing personnel could be brought about." But, Hitler also clearly enunciated one more reason: he considered these euthanasia killings "humane." He insisted that the euthanasia deaths be absolutely painless; he insisted that only doctors perform the euthanasia. And, he specifically disallowed Jews from benefitting from this "mercy killing." Euthanasia, or a "mercy death," was allowed only for Aryans. Jewish patients in German psychiatric hospitals were deported to concentration camps to deny them the Gnadentod of euthanasia.

In October 1939, Hitler hand wrote his secret euthanasia order. "Reichsleiter [Philip] Bouhler and Dr. [Karl] Brandt are charged with the responsibility for expanding the authority of

[2] Supra, pp. 139-140, EIR Special Report.

physicians, to be designated by name, to the end that patients considered incurable according to the best available human judgment of their state of health, can be accorded a mercy death."

At the top of the order, Hitler wrote: "Vernichtung lebensunwerten Lebens" or, "The Destruction of Lives Unworthy of Life."

Before the International Military Tribunal, one of the cases brought for crimes against humanity for which individuals were indicted, tried, and executed, was the crime of euthanasia committed by Germans against German civilians. This charge was based on Control Council Law No. 10 of December 20, 1945, issued to implement the Four Power Agreement by the United States, United Kingdom, French Provisional Government and Soviet Union through their commanding generals at Berlin. Article II 1.(C) defined crimes against humanity as:

> Atrocities and offenses, including but not limited to murder, extermination, enslavement, deportation, imprisonment, torture, rape, or other inhumane acts committed against any civilian population ... whether or not in violation of the domestic laws of the country where perpetrated.

The U.S. Military Tribunal specifically applied the definition of a crime against humanity to cover German victims, not just conquered civilians:

> The words "civilian population" cannot possibly be construed to exclude German civilians. If Germans are deemed excluded [from the class of victims], there is little or nothing left to give purpose to the concept of crimes against humanity ... It is one of the very purposes of the concept of crimes against humanity ... to reach the systematic commission of atrocities and offenses by a state against its own people."

Count III of the indictment in the case, United States of America v. Karl Brandt, et al., charged in pertinent part:

> Defendants Karl Brandt, Blome, Brack and Hoven unlawfully, willfully, and knowingly committed crimes against humanity, as defined by Article II of Control Council Law No. 10 in that they were principles in, accessories to, ordered, abetted, took a consenting part in, and were connected with plans and enterprises involving the execution of the so-called "euthanasia" program of the German Reich, in the course of which the defendants herein murdered hundreds of thousands of human beings, including German civilians, as well as civilians of other nations.
>
> This program involved the systematic and secret execution of the aged, insane, incurably ill, of deformed children, and other persons, by gas, lethal injections, and diverse other means in nursing homes, hospitals, and asylums. Such persons were regarded as "useless eaters" and a burden to the German war machine.

Evidence presented in the course of the Brandt trial included evidence that deformed or defective newborn infants were among the victims of the euthanasia program.

> The names of newly born children who were deformed or partly paralyzed, or mentally

> deficient, were submitted to the health authorities and finally to a Reich agency of Berlin ... A short time after the reports were filed, the County Health Authorities of the respective districts received an order that these children should be sent to a special institution for special modern therapy. I know from hundreds of cases, that this "special modern therapy" was nothing less than the killing of these children ... Another method of killing so-called "useless eaters" was to starve them ... This method was apparently considered very good, because the victims would appear to have died a "natural death." This was a way of camouflaging the killing procedure.

Affidavit of Gerhard Schmidt, Director of the Haar-Eglfing Insane Asylum, dated 28 March 1946, Document No. 3816-PS.

Dr. Karl Brandt, like Dr. Jack Kevorkian, also clothed acts of genocide and euthanasia in "humanitarian" garb, saying at sentencing:

> ... I am fully conscious that when I said "Yes" to euthanasia I did so with the deepest conviction, just as it is my conviction today, that it was right. Death can mean deliverance. Death is life -- just as much as birth. It was never meant to be murder. I bear a burden, but it is not the burden of a crime. I bear this burden of mine, though with a heavy heart, as my responsibility. I stand before it, and before my conscience, as a man and as a doctor.

Final Statement of defendant Karl Brandt, 19 July 1947, Transcript of Trials of War Criminals before the Nuremberg

Military Tribunals under Code Council Law. No. 10, trans. pp. 11311-11314.

On August 20, 1947, Dr. Karl Brandt was adjudged guilty of war crimes, guilty of crimes against humanity, of conspiring to commit war crimes and crimes against humanity, and of membership in an illegal organization, and was sentenced to "death by hanging" by order of the U.S. Military Tribunal. It is only just that it is no defense to be a sincere Nazi.

There is no difference between Hitler's perspective and that of the Second and Ninth Circuit. The Second Circuit cites New York's long-standing contention that its principle interest is in preserving the life of all its citizens at all times and under all conditions. But, the Second Circuit asks: "Of what interest can the state possible have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes." Quill, et al v. Vacco, 80 F.3d, 716, 729.

The Ninth Circuit states:

> While the state has a legitimate interest in preventing suicides in general, that interest, like the state's interest in preserving life, is substantially diminished in the case of terminally ill, competent adults who wish to die.

Compassion in Dying v. Washington, under the State's Interest, 2, a; 79 F.3d 790, 829

The "lives not worthy of life" ethic, as the Ninth Circuit finds, is already established within state statutes and we ask the Court not to compound that wrong with another.

> As the laws in state after state demonstrate, even though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die ...

Compassion in Dying v Washington, supra, 820.

The Ninth Circuit continues:

> When participants are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling. Thus, while the state may still seek to prolong the lives of terminally ill or comatose patients ... the strength of the state's interest is substantially reduced in such circumstances.

Compassion in Dying v Washington, supra, 820.

If anything, the Ninth Circuit's perspective is a chilling embrace of Hitler's, as Hitler wrote in his second book, unpublished until the 1960s after his death:

> In truth that struggle for daily bread, both in peace and in war, is an eternal battle against thousands upon thousands of obstacles, just as life itself is an eternal struggle against death. For men know as little why they live, as does any other creature of the world. Only life is filled with the longing to preserve itself ...

> Countless are the species of all the Earth's organisms, unlimited at any moment in all individuals is their instinct for self-preservation as well as their longing for continuance ... THEREFORE, HE WHO WANTS TO LIVE MUST FIGHT AND HE WHO DOES NOT WANT TO FIGHT IN THIS WORLD OF ETERNAL STRUGGLE, DOES NOT DESERVE TO BE ALIVE.

Hitler's Secret Book, Grove Press, New York, 1962 (emphasis added).

Is Hitler's social Darwinian ethic all that different from that of the Ninth Circuit's? Effectively, the Ninth Circuit said that when a patient is too ill or no longer wishes to fight for his life, then he no longer is fit to live within the embrace of society's protection and support. Hitler explicitly wrote: "If the power to fight for one's own health is no longer present, THE RIGHT TO LIVE IN THIS WORLD OF STRUGGLE ENDS." (Emphasis added.)

Such is the premise, whenever a state or a court bestows the "right" for an individual to take his life, or, to allow others to do so for him. That physicians are called upon to act to render that "right" out of some misplaced compassion, does not stand the historic test of Nuremberg.

> It should be noted that Dr. Timothy Quill, a forceful and eloquent proponent of physician-assisted suicide, would not limit that right to the terminally ill. As he explains, he does not want "to arbitrarily exclude persons with incurable, but not imminently terminal, progressive illness." But why stop there? Is it any less arbitrary to exclude the quadriplegic? The

> victim of a paralytic stroke? The mangled survivor of a road accident?

Yale Kamisar, Against Assisted Suicide - Even a Very Limited Form, U. Det. Mercy L. Rev., Vol. 72, Issue 4 (1995) (emphasis added).

For America, the Nuremberg judgments have precedential value. The United States led in the establishment of the Nuremberg Tribunals. By January of 1945, the United States government had decided to conduct international trials. The three other major allied powers accepted the American program at the San Francisco United Nations Conference. Associate Justice Robert Jackson was appointed by President Truman as head of the United States delegation and future chief counsel for the American prosecution, who was the guiding spirit and practical planner. Nineteen other governments, members of the United Nations, adhered to the Four Power Agreement.

William J. Bosch, Judgment on Nuremberg, University of North Carolina Press, 1970, analyzed the response of international law jurists and wrote at page 235:

> International lawyers condemning the Tribunal often reached their conclusions because they subscribed to the doctrine of legal positivism. This judicial theory maintains that the sovereign state was the only subject of international law and that a nation has no obligations except those created by explicit agreements or clear compliance with a general custom. Legal positivism, therefore, looked askance on Nuremberg's indictment for crimes against peace and humanity derived from an alleged international common law, on the court's

> principle of individual responsibility, and on the judges' affirmation of a progressive, dynamic law of the nations which could not be emasculated by uncompromising demands for precedence.

Adherents of the natural-law philosophy generally endorsed Nuremberg because the court supposedly vindicated their theory. This theory declared that law was derived from the ontological nature of things, that rights and duties were discovered by reason rather than made by the sovereign's will, and that consequently there existed immutable, inalienable human rights and a fundamental law above all human legislation.

> Nuremberg embodied tenets of the natural-law philosophy, for the court affirmed individual accountability, claimed to be speaking for a rule of reason which judged the actions of all men and nations, and decided that, whatever the lack of statutory enactments, the laws of God and nature were enough to condemn the Nazis.

It is submitted to this Court that the Tribunal's actions taken at Nuremberg were just, necessary, and legally valid under international law and our own Constitution. Additional authority was provided when, on December 11, 1946, the General Assembly of the United Nations "affirmed" the principles of international law recognized by the Charter of the Nuremberg Tribunal and the judgment of the Tribunal. The Nuremberg ban on aggressive war has been repeatedly invoked by the United Nations. The prosecutions for crimes against humanity, including governmentally sanctioned euthanasia, are such a national expression of the American concept of the good,

that to turn one's back on Nuremberg is tantamount to retreating in the face of the enemy.

It is submitted that Kevorkian's activities have continued because of this subtle shift that Dr. Alexander describes. The shift has been reinforced by the massive propaganda (major media coverage) which treats Kevorkian as a victim and angel of mercy, whose offense lies merely in being unregulated. The Ninth and Second Circuit Courts of Appeals majorities contribute to the institutionalization of Kevorkian's conduct, providing a gloss of legality and aim at striking down state laws, such as Michigan's statute prohibiting assisted suicide, which specifically forbids prescribing, dispensing, or administering medications or procedures if done with the intent to cause death. MCL 752.1027 (WEST) 1995. That statute expired and People v. Kevorkian, 447 Mich. 436 (1994); 527 N.W. 2d 714, (1994) was based on the common law prohibition.

It is submitted by this writer, that the veterans of World War II made possible this nation's ability to survive as the greatest and finest experiment in democratic republican representative self-government under the longest living constitution that has ever existed. Its continuance depends upon people who will live by and die for the principles of the American Constitution and the Declaration of Independence. This nation, acting through its Supreme Court, cannot approve of or allow its citizens to believe that they have a protected right to commit suicide. The American population has a right to life, liberty, and the pursuit of happiness, but should be encouraged by decisions of this Court to live that life contributing to the common good of their fellows, their posterity, and their country, thereby providing an example to all nations of the world and showing that the Judgment at Nuremberg was not a mere act of vengeance against losers. Almost a million Americans since 1776 have died fighting to uphold this nation and its

Constitution, and they did not die fighting to protect a fundamental right to commit suicide.

CONCLUSION

Wherefore, the members of the Court are respectfully urged, on behalf of the world membership of the Schiller Institute, including Germans liberated from German Nazis, not to forget them and their struggle to hold up the spirit of our Revolution and our Constitution as guides in building nation states to exist in peace with the lives of their citizens enriched by our national example of not allowing Americans to kill Americans in Hitler's footsteps.

For the foregoing reasons of law and policy, the Schiller Institute urges this Court to reverse the decision of the Ninth Circuit Court of Appeals.

Respectfully submitted,

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Dated: November 6, 1996

APPENDIX

AGREEMENT BY THE GOVERNMENT OF THE UNITED STATES OF AMERICA, THE PROVISIONAL GOVERNMENT OF THE FRENCH REPUBLIC, THE GOVERNMENT OF THE UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND AND THE GOVERNMENT OF THE UNION OF SOVIET SOCIALIST REPUBLICS FOR THE PROSECUTION AND PUNISHMENT OF THE MAJOR WAR CRIMINALS OF THE EUROPEAN AXIS.

WHEREAS the United Nations have from time to time made declaration of their intention that War Criminals shall be brought to justice;

AND WHEREAS the Moscow Declaration of the 30th October 1943 on German atrocities in Occupied Europe stated that those German Officers and men and members of the Nazi Party who have been responsible for or have taken a consenting part in atrocities and crimes will be sent back to the countries in which their abominable deeds were done in order that they may be judged and punished according to the laws of these liberated countries and of the free Governments that will be created therein;

AND WHEREAS this Declaration was stated to be without prejudice to the case of major criminals whose offenses have no particular geographic location and who will be punished by the joint decision of the Governments of the Allies;

NOW THEREFORE the Government of the United States of America, the Provisional Government of the French Republic, the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Union of Soviet Socialist Republics (hereinafter called "the Signatories") acting in the interests of all the United Nations and by their representatives duly authorized thereto have concluded this Agreement.

Article 1. There shall be established after consultation with the Control Council for Germany an International Military Tribunal for the trial of war criminals whose offenses have no particular geographical location whether they be accused individually or in their capacity as members of organizations or groups or in both capacities.

Article 2. The constitution, jurisdiction and functions of the International Military Tribunal shall be those set out in the Charter annexed to this Agreement, which Charter shall from an integral part of this Agreement.

Article 3. Each of the Signatories shall take the necessary steps to make available for the investigation of the charges and trial the major war criminals detained by them who are to be tried by the International Military Tribunal. The Signatories shall also use their best endeavors to make available for investigation of the charges against and the trial before the International Military Tribunal such of the major war criminals as are not in the territories of any of the Signatories.

Article 4. Nothing in this Agreement shall prejudice the provisions established by the Moscow Declaration concerning the return of war criminals to the countries where they committed their crimes.

Article 5. Any Government of the United Nations may adhere to this Agreement by notice given through the diplomatic channel to the Government of the United Kingdom, who shall inform the other Signatory and adhering Gover nments of each such adherence.

Article 6. Nothing in this Agreement shall prejudice the jurisdiction or the powers of any national or occupation court established or to be established in any allied territory or in Germany for the trial of war criminals.

Article 7. This Agreement shall come into force on the day of signature and remain in force for the period of one year and shall continue thereafter, subject to the right of any Signatory to give, through the diplomatic channel, one month's notice of intention to terminate it. Such termination shall not

prejudice any proceedings already taken or any findings already made in pursuance of this Agreement.

IN WITNESS WHEREOF the Undersigned have signed the present Agreement.

Done in quadruplicate in London this 8th day of August 1945 each in English, French and Russian, and each text to have equal authenticity.

For the Government of the United States of America
Robert H. Jackson

For the Provisional Government of the French Republic
Robert Falco

For the Government of the United Kingdom of Great Britain and Northern Ireland
Jowitt

For the Government of Union of Soviet Socialist Republics
I.T. Nikitchenko (and) A.N. Trainin

CHARTER OF THE INTERNATIONAL MILITARY TRIBUNAL

I. CONSTITUTION OF THE TRIBUNAL

Article 1. In pursuance of the Agreement signed on the 8th day of August 1945 by the Government of the United States of America, the Provisional Government of the French Republic, the Government of the United Kingdom of Great Britain and Northern Ireland and the Government of the Union of Soviet Socialist Republics, there shall be established an Internatioal Military Tribunal (hereinafter called "the Tribunal") for the just and prompt trial and punishment of the major war criminals of the European Axis.

Article 2. The Tribunal shall consist of four members, each with an alternate. One member and one alternate shall be

appointed by each of the Signatories. The alternates shall, so far as they are able, be present at all sessions of the Tribunal. In case of illness of any member of the Tribunal or his incapacity for some other reason to fulfill his functions, his alternate shall take his place.

Article 3. Neither the Tribunal, its members nor their alternates can be challenged by the prosecution, or by the Defendants or their Counsel. Each Signatory may replace its member of the Tribunal or his alternate for reasons of health or for other good reasons, except that no replacement may take place during a Trial, other than by an alternate.

Article 4.

(a) The presence of all four members of the Tribunal or the alternate for any absent member shall be necessary to constitute the quorum.

(b) The members of the Tribunal shall, before any trial begins, agree among themselves upon the selection from their number of a President, and the President shall hold office during that trial, or as may otherwise be agreed by a vote of not less than three members. The principle of rotation of presidency for successive trials is agreed. If, however, a session of the Tribunal takes place on the territory of one of the four Signatories, the representative of that Signatory on the Tribunal shall preside.

(c) Save as aforesaid the Tribunal shall take decisions by a majority vote and in case the votes are evenly divided, the vote of the President shall be decisive: provided always that convictions and sentences shall only be imposed by the affirmative votes of at least three members of the Tribunal.

Article 5. In case of need and depending on the number of the matters to be tried, other Tribunals may be set up; and the establishment, functions, and procedure of each Tribunal shall be identical and shall be governed by this Charter.

II. JURISDICTION AND GENERAL PRINCIPLES

Article 6. The Tribunal established by the Agreement referred to in Article I hereof for the trial and punishment of the major war criminals of the European Axis countries shall have the power to try and punish persons who, acting in the interests of the European Axis countries, whether as individuals or as members of organizations, committed any of the following crimes.

The following acts, or any of them, are crimes coming within the jurisdiction of the Tribunal for which there shall be individual responsibility:

(a) Crimes Against Peace: namely, planning, preparation, initiation or waging of a war of aggression or a war in violation of international treaties, agreements or assurances, or participation in a common plan or conspiracy for the accomplishment of any of the foregoing;

(b) War Crimes: namely, violations of the laws or customs of war. Such violations shall include, but not be limited to, murder, ill-treatment or deportation to slave labor or for any other purpose of civilian population of or in occupied territory, murder or ill-treatment of prisoners of war or persons on the seas, killing of hostages, plunder of public or private property, wanton destruction of cities, towns or villages, or devastation not justified by military necessity;

(c) Crimes Against Humanity: namely, murder, extermination, enslavement, deportation, and other inhumane acts committed against any civilian population, before or during the war; or persecutions on political, racial or religious grounds in execution of or in connection with any crime within the jurisdiction of the Tribunal, whether or not in violation of domestic law of the country where perpetrated.

Leaders, organizers, instigators and accomplices participating in the formulation or execution of a common plan or conspiracy to commit any of the foregoing crimes are

responsible for all acts performed by any persons in execution of such plan.

Article 7. The official position of defendants, whether as Heads of State or respobsible officials in Government Departments, shall not be considered as freeing them from responsibility or mitigating punishment.

Article 8. The fact that the Defendant acted pursuant to order of his Government or of a superior shall not free him from responsibility, but may be considered in mitigation of punishment if the Tribunal determine that justice so requires.

Article 9. At the trial of any individual member of any group or organization the Tribunal may declare (in connection with any act of which the individual may be convicted) that the group or organization of which the individual was a member was a criminal organization.

After receipt of the Indictment the Tribunal shall give such notice as it thinks fit that the prosecution intends to ask the Tribunal to make such declaration and any member of the organization will be entitled to apply to the Tribunal for leave to be heard by the Tribunal upon the question of the criminal character of the organization. The Tribunal shall have power to allow or reject the application. If the application is allowed, the Tribunal may direct in what manner the applicants shall be represented and heard.

Article 10. In cases where a group or organization is declared criminal by the Tribunal, the competent national authority of any Signatory shall have the right to bring individuals to trial for membership therein before national, military or occupation courts. In any such case the criminal nature of the group or organization is considered proved and shall not be questioned.

Article 11. Any person convicted by the Tribunal may be charged before a national, military or occupation court, referred to in Article 10 of this Charter, with a crime other than of membership in a criminal group or organization and such court may, after convicting him, impose upon him

punishment independent of and additional to the punishment imposed by the Tribunal for participation in the criminal activities of such group or organization.

Article 12. The Tribunal shall have the right to take proceedings against a person charged with crimes set out in Article 6 of this Charter in his absence, if he has not been found or if the Tribunal, for any reason, finds it necessary, in the interests of justice, to conduct the hearing in his absence.

Article 13. The Tribunal shall draw up rules for its procedure. These rules shall not be inconsistent with the provisions of this Charter.

III. COMMITTEE FOR THE INVESTIGATION AND PROSECUTION OF MAJOR WAR CRIMINALS

Article 14. Each Signatory shall appoint a Chief Prosecutor for the investigation of the charges against and the prosecution of major war criminals.

The Chief Prosecutors shall act as a committee for the following purposes:

(a) to agree upon a plan of the individual work of each of the Chief Prosecutors and his staff,

(b) to settle the final designation of major war criminals to be tried by the Tribunal,

(c) to approve the Indictment and the documents to be submitted therewith,

(d) to lodge the Indictment and the accompanying documents with the Tribunal.

(e) to draw up and to recommend to the Tribunal for its approval draft rules of procedure, contemplated by Article 13 of this Charter. The Tribunal shall have power to accept, with or without amendments, or to reject, the rules so recommended.

The Committee shall act in all the above matters by a majority vote and shall appoint a Chairman as may be

convenient and in accordance with the principle of rotation provided that if there is an equal division of vote concerning the designation of a Defendant to be tried by the Tribunal, or the crimes with which he shall be charged, that proposal will be adopted which was made by the party which proposed that the particular Defendant be tried, or the particular charges be preferred against him.

Article 15. The Chief Prosecutors shall individually, and acting in collaboration with one another also undertake the following duties:

(a) investigation, collection and production before or at the Trial of all necessary evidence,

(b) the preparation of the Indictment for approval by the Committee in accordance with paragraph (c) if Article 14 hereof,

(c) the prelimiary examination of all necessary witnesses and of the Defendants,

(d) to act as prosecutor at the Trial,

(e) to appoint representative to carry out such duties as may be assigned to them,

(f) to undertake such other matters as may appear necessary to them for the purposes of the preparation for and conduct of the Trial.

It is understood that no witness or Defendant detained by any Signatory shall be taken out of the possession of that Signatory without its assent.

IV. FAIR TRIAL FOR DEFENDANTS

Article 16. In order to ensure fair trial for the Defendants, the following procedure shall be followed:

(a) The Indictment shall include full particulars specifying in detail the charges against the Defendants. A copy of the Indictment and of all the documents lodged with the Indictment, translated into a language which he understands,

shall be furnished to the Defendant at a reasonable time before the Trial.

(b) During any preliminary examination or trial of a Defendant he shall have the right to give any explanation relevant to the charges made against him.

(c) A preliminary examination of a defendant and his Trial shall be conducted in, or translated into, a language which the Defendant understands.

(d) A defendant shall have the right to conduct his own defense before the Tribunal or to have the assistance of Counsel.

(e) A defendant shall have the right through himself or through his counsel to present evidence at the Trial in support of his defense, and to cross-examine any witness called by the Prosecution.

V. POWERS OF THE TRIBUNAL AND CONDUCT OF THE TRIAL

Article 17. The Tribunal shall have the power

(a) to summon witnesses to the Trial and to require their attendance and testimony and to put questions to them,

(b) to interrogate any Defendant,

(c) to require the production of documents and other evidentiary material,

(d) to administer oaths to witnesses,

(e) to appoint officers for the carrying out of any task designated by the Tribunal including the power to have evidence taken on commission.

Article 18. The Tribunal shall

(a) confine the Trial strictly to an expeditious hearing of the issues raised by the charges,

(b) take strict measures to prevent any action which will cause unreasonable delay, and rule out irrelevant issues and statements of any kind whatsoever,

(c) deal summarily with any contumacy, imposing appropriate punishment, including exclusion of any Defendant or his Counsel from some or all further proceedings, but without prejudice to the determination of the charges.

Article 19. The Tribunal shall not be bound by technical rules of evidence. It shall adopt and apply to the greatest possible extent expeditious and nontechnical procedure, and shall admit any evidence which it deems to have probative value.

Article 20. The Tribunal may require to be informed of the nature of any evidence before it is offered so that it may rule upon the relevance thereof.

Article 21. The Tribunal shall not require proof of facts of common knowledge but shall take judicial notice thereof. It shall also take judicial notice of official governmental documents and reports of the United Nations, including the acts and documents of the committees set up in the various allied countries for the investigation of war crimes, and the records and findings of military or other Tribunals of any of the United Nations.

Article 22. The permanent seat of the Tribunal shall be in Berlin. The first meetings of the members of the Tribunal and of the Chief Prosecutors shall be held at Berlin in a place to be designated by the Control Council for Germany. The first trial shall be held at Nürnberg, and any subsequent trials shall be held at such places as the Tribunal may decide.

Article 23. One or more of the Chief Proseutors may take part in the prosecution at each Trial. The function of any Chief Prosecuter may may be discharged by him personally, or by any person or persons authorized by him. The function of Counsel for a Defendant may he discharged at the Defendants request by any Counsel professionally qualified to conduct cases before the Courts of his own Country, or by any other person who may be specially authorized thereto by the Tribunal.

Article 24. The proceedings at the Trial shall take the following course:

(a) The Indictment shall be read in court.

(b) The Tribunal shall ask each Defendant whether he pleads "guilty" or "not guilty."

(c) The prosecution shall make an opening statement.

(d) The Tribunal shall ask the prosecution and the defense what evidence (if any) they wish to submit to the Tribunal, and the Tribunal shall rule upon the admissibility of any such evidence.

(e) The witnesses for the Prosecution shall be examined and after that the witnesses for the Defense. Thereafter such rebutting evidence as may be held by the Tribunal to be admissible shall be called by either the Prosecution or the Defense.

(f) The Tribunal may put any question to any witness and to any Defendant, at any time.

(g) The Prosecution and the Defense shall interrogate and may cross examine any witnesses and any Defendant who gives testimony.

(h) The Defense shall address the court.

(i) The Prosecution shall address the court.

(j) Each Defendant may make a statement to the Tribunal.

(k) The Tribunal shall deliver judgment and pronounce sentence.

Article 25. All official documents shall be produced, and all court proceedings conducted, in English, French, and Russian, and in the language of the Defendant. So much of the record and of the proceedings may also be translated into the language of any country in which the Tribunal is sitting, as the Tribunal considers desirable in the interests of justice and public opinion.

VI. JUDGMENT AND SENTENCE

Article 26. The judgment of the Tribunal as to the guilt or the innocence of any Defendant shall give the reasons on which it is based, and shall be final and not subject to review.

Article 27. The Tribunal shall have the right to impose upon a Defendant on conviction, death or such other punishment as shall be determined by it to be just.

Article 28. In addition to any punishment imposed by it, the Tribunal shall have the right to deprive the convicted person of any stolen property and order its delivery to the Control Council for Germany.

Article 29. In case of guilt, sentences shall be carried out in accordance with the orders of the Control Council for Germany, which may at any time reduce or otherwise alter the sentences, but may not increase the severity thereof. If the Control Council for Germany, after any Defendant has been convicted and sentenced, discovers fresh evidence which, in its opinion would found a fresh charge against him, the Council shall report accordingly to the Committee established under Article 14 hereof, for such action as they may consider proper, having regard to the interests of justice.

VII. EXPENSES

Article 30. The expenses of the Tribunal and of the Trials, shall be charged by the Signatories against the funds allotted for maintenance of the Control Council for Germany.

VIII. EVIDENCE AND ARGUMENTS ON IMPORTANT ASPECTS OF THE CASE

A. Applicability of Control Council Law No. 10 to Offenses Against Germans During the War

a. Introduction

Under count III of the indictment, "Crimes against Humanity", the prosecution alleged that the defendants had engaged in medical experiments "*upon German civilians* and nationals of other countries" and that the defendants had participated in executing "the so-called 'euthanasia program' of the German Reich in the course of which the defendants herein murdered hundreds of thousands of human beings, *including German civilians*, as well as civilians of other nations." [Emphasis added.] Insofar as these offenses involved German nationals, the defense argued that international law was not applicable. The defense argued that under the Charter annexed to the London Agreement, crimes against humanity within the meaning of the Charter do not exist unless offenses are committed "in the execution of, or in connection with, any crime within the jurisdiction of the Tribunal". Although the analagous provision of Control Council Law No. 10 does not include the words of limitation "in the execution of, or in connection with any crime within the jurisdiction of the Tribunal", the defense argued that Control Council Law No. 10 was only "an implementation law" of the London Agreement and Charter, and hence could not increase the scope of the offenses defined by the London Charter. Pointing to the section of the judgment of the International Military Tribunal entitled "The law relating to war crimes and crimes against

humanity",[1] the defense noted that the IMT stated: "to constitute crimes against humanity, the acts relied on before the outbreak of war must have been in execution of, or in connection with, any crime within the jurisdiction of the Tribunal",[2] that is crimes against peace or war crimes. Although the indictment in the Medical Case did not allege that crimes were committed against German nationals before the outbreak of the war on 1 September 1939, the defense further argued that any offenses against German nationals committed after 1939 had not been shown
to be "in execution of, or in connection with" crimes against peace and war crimes and hence were not cognizable as crimes within the jurisdiction of the Tribunal.

Extracts of the closing statement of the prosecution appear below on pages 910 to 915. A summation of the evidence on this question by the defense has been taken from the closing brief for defendant Karl Brant. It appears below on pages 915-925.

b. Selection from the Argumentation of The Prosecution

EXTRACTS FROM THE CLOSING STATEMENT OF THE PROSECUTION[3]

The Law of the Case

Before proceeding to outline the prosecutions case, it way perhaps be desirable to anticipate several legal questions

[1] Trial of the Major War Criminals, vol. I, pp. 253-255, Nuremberg, 1947.

[2] *Ibid.*, p. 254.

[3] Closing statement is recorded in memographed transcript, 14 July 1947, pp. 10718-10794.

which will undoubtedly be raised with respect to war crimes and crimes against humanity, as defined in Article II of Control Council Law No. 10. Law No. 10 is of course the law of this case and its terms are conclusive upon every parto to this proceeding. This tribunal is, we respectfully subnit, bound by the definitions in Law No. 10, just as the International Military Tribunal was bound by the definitions in the London Charter. It was stated in the IMT judgment that:[2]

> "The jurisdiction of the Tribunal is devined in the Agreement and Charter, and the crimes coming the jurisdiction of the Tribunal, for which there shall be individual responsibility, are set out in Article 6. The law of the Charter is decisive and binding upon the Tribunal * * *"

In outlining briefly the prosecution's conception of some of the legal principles underlying war crimes and crimes against humanity, I shall, with the Tribunal's permission, adopt some of the language from the opening statement of the prosecution n the case against Friedrich Flick, et al., now pending before Tribunal IV. [See Vol. VI.] General Taylor there said:

"Law No. 10 is * * * a legislative enactment by the Control One of the infirmities of dictatorship is that, when it suffers irretrievable and final military disaster, it usually crumbles into nothing and leaves the victims of its tyranny leaderless amidst political chaos. The Third Reich had ruthlessly hunted down every man and woman in Germany who sought to express political ideas or develop political leadership outside of the bestial ideology of nazism. When the Third Reich collapsed, Germany tumbled into a political vacuum. The declaration by the Allied Powers of 5 June 1945 announced the 'assumption of supreme authority' in Germany 'for the

[2] Trial of the Major War Criminals, vol. I, p. 218, Nuremberg, 1947.

maintenance of order' and 'for the administration of the country', and recited that--

> 'There is no central government authority in Germany capable of accepting responsibility for the maintenance of order, the administration of the country, and compliance with the requirements of the victorious powers.'

"Following this declaration, the Control board was constituted as the repository of centralized authority in Germany. Law No. 10 is an enactment of that body and is the law of Germany, although its substantive provisions derive from and embody the law of nations. The Nuerenberg Military Tribunals are established under ths authority of Law No. 10,[1] and they render judgment not only under international law as enacted in Law No. 10, but under the law of Germany as enacted in Law No. 10. The Tribunals, in short, enforce both international law and German law, and in interpreting and applying Law No. 10, they must view Law No. 10 not only as a declaration of international law, but as an enactment of the occupying powers for the governance of and administration of Justice in Germany. The enactment of Law No. 10 was an exercise of legislative powers by the four countries to which the Third Reich surrendered, and, as was held by the International Military Tribunal:[2]

'* * * the undoubted right of these countries to legislate for the occupied territories has has been recognized by the civilized world.'"

[1] Control Council Law No. 10, Article III, par. 1(d) and 2, Military Government Ordinance No. 7, Article II.

[2] Trial of the Major War Criminals, vol. I, p. 218, Nuremberg, 1947.

War crimes are defined in Law No. 10 as atrocities or offenses in violation of the laws of customs of war. This definition is based primarily upon the Hague Convention of 1907 and the Geneva Convention of 1929, which declare the law of nations at those times with respect to land warfare, the treatment of prisoners of war, the rights and duties of a belligerent power when occupying territory of a hostile state and other matters. The laws customs of war apply between beligerents, but not domestically or among allies. Crimes by German nationals against other German nationals are not war crimes, nor are acts by German national against Hungarians of Romanians. The war crimes charged in this indictment occurred after 1 September 1939, and it is therefore unnecessary to consider the somewhat narrow limitation of the scope of war crimes by the International Military Tribunal to the acts committed after the outbreak of war. One might argue that the occupations of Austria and the Sudatenland in 1938 and of Bohemia and Moravia in March 1939, were sufficiently similar to a state of beligerency to bring the laws of war into effect, but such questions are academic for purposes of this case.

In connection with the charge of crimes against humanity, it is also anticipated that an argument will be made by the defense to the effect that crimes committed by German nationals against other nationals cannot constitute crimes against humanity as defined by Article II of Control Council Law No. 10 and hence are not within the jurisdiction of this Tribunal. The evidence of the prosecution has proved that in substantially all of the experiments prisoners of war or civilians from German-occupied territories were used as subjects. This proof stands uncontradicted save by general statements of the defendants that they were told by Himmler or some unidentified person that the experimental subjects were all German criminals or that the subjects all spoke fluent German. Thus, for the most part the acts here in issue constitute war crimes and hence, at the same time crimes against humanity. Certainly

there has been no proof whatever that an order was ever issued restricting the experimental subjects to German criminals as distnguished from non-German nationals. If, in this or that minor instance, the proof has not disclosed the precise nationality of the unfortunate victims or has even shown them to be Germans, we may rest assured that it was merely a chance occurance.

Be that as it may, the prosecution does not wish to ignore a challange to the jurisdiction of the Tribunal even though it is of minor importance to this case. One thing should be made clear at the outset: We are not here concerned with any question as to jurisdiction over crimes committed before 1 September 1939, whether against German nationals or otherwise. That subjeet has been mooted and is in issue in another case now on trial, but the crimes in this case all occurred after the war began.

Moreover, we are not concerned with the question whether crimes against humanity must have been committed "in execution of or in connection with any crimes within the jurisdiction of the Tribunal." The International Military Tribunal construed its Charter as requiring that crimes against humanity be committed in execution of, or in connection with, the crime of aggressive war. Whatever the merit of that holding, the language of the Charter of the International Military Tribunal which led to it is not included in the definition of crimes against humanity in Control Council Law No. 10. There can be no doubt that crimes against humanity as defined in Law No. 10 stand on an independent footing and constitute crimes *per se*. In any event, the crimes with which this case is concerned were in fact all "committe in execution of, or in connection with, the aggressive war." This is true not only of the medical experiments, but also of the Euthanasia Program, pursuant

to which a large number of non-German nationals were killed. The judgment of the International Military Tribunal expressly so holds.[1]

Thus, it is clear that the only issue which is raised in this as to crimes against humanity is whether the Tribunal has jurisdiction over crimes committed by Germans against Germans. Does the definition of crimes against humanity in Control Council Law No. 10 comprehend crimes by Germans against Germans of the type with which this case is concerned? The provisions of Law No. 10 are binding upon the Triblinal as the law to be applied to the case.[2] The provisions of Section 1(c) of Article II are clear and unambiguous. Crimes against humanity are there defined as--

> "Atrocities and offenses, including but not limited to murder extermination, enslavement, deportation, imprisonment, torture,rape or other inhumane acts committed against any *civilian population,* or persecutions on political, racial, or religious grounds whether or not in violation of the domestic laws of the country where perpetrated." [Emphasis supplied.]

The words "any civilian population" cannot possibly be construed to exclude German civilians. If Germans are deemed to be excluded, there is little or nothing left to give purpose to the concept of crimes against humanity. War crimes include all acts listed in the definition of crimes against humnity when committed against prisoners of war and the civilian population of occupied territory. The only remaining significant groups are Germans and nationals of the satellite countries, such as Hungary or Romania. It is one of the very purposes of the

[1] *Ibid.*, pp. 231, 247, 252, 254, 301.

[2] *Ibid.*, pp. 174, 253.

concept of crimes against humanity, not only as set forth in Law No. 10 but also as long recognized by international law, to reach the systematic commission of atrocities and offenses by a state against its own people. The concluding phrase of the definition of crimes against humanity, *which is in the alternative*, makes it quite clear that crimes by Germans against Germans are within the jurisdiction of this Tribunal. It reads "or persecutions on political, racial, or religious grounds *whether or not in violation of the domestic laws of the country where perpetrated.*" This reference to "domestic laws" can only mean discriminatory and oppressive legislation directed against a state's own people, as for example, the Nuremburg Laws against German Jews. [Emphasis supplied.]

The matter is put quite beyond doubt by Article III of Law No. 10 which authorizes each of the occupying powers to arrest persons suspected of having commited crimes defined in Law No. 10, and to bring them to trial "before an appropriate tribunal." Paragraph 1(d) of Article III further provides that--

> "Such Tribunal may, in the case of crimes committed by persons of German citizenship or nationality against other persons of German citizenship or nationality, or stateless persons be a German court, if authorized by the occupying authorities."

This constitutes an explicit recognition that acts committed by Germans against other Germans are punishable as crimes under Law No. 10 according to the definitions contained therein in the discretion of the occupying power. This has particular reference to crimes against humanity, since the application of crimes against peace and war crimes while possible, is almost entirely theoretical. If the occupying power fails to authorize German courts to try crimes committed by Germans against other Germans (and in the American zone of occupation no such authorization has been given), then these cases are tried

only before non-German tribunals, such as these Military Tribunals.

What would be the effect of a holding that crimes by Germans against Germans under no circumstances be within the jurisdiction of the Tribunal? Is this Tribunal to ignore the proof that tens of thousands of Germans were exterminated pursuant to a secret decree, because a group of criminals in control of a police state thought them "useless eaters" and an unnecessary burden, or that German prisoners were murdered and mistreated by thousands in concentration camps, in part by medical experimentation? Military Tribunal II in the Milch case held that crimes against nationals of Hungary and Romania were crimes against humanity. There is certainly no reason in saying that there is jurisdiction over crimes by Germans against Hungarians but not against Germans.

The judgment of the International Military Tribunal shows a clear recognition of its jurisdiction over crimes by Germans against Germans. After reviewing a large number of inhumane acts in connection with war crimes and crimes against humanity, the Tribunal concluded by saying that--

> "* * * from the beginning of the war in 1939 war crimes were committed on a vast scale, which were also crimes against humanity, and insofar as the inhhumane acts charged in the indictment, and committed after the beginning of the war, did not constitute war crimes, they were all committed in execution of, or in connection with the aggressive war, and therefore constituted crimes against humanity."[1]

Since war crimes are necessarily also crimes against humanity, the broader definition of the latter can only refer to crimes not covered by the former, namely, crimes against Germans and

[1] Ibid, pp. 254, 255

nationals of countries other than those occupyied by Germany. Moreover, the prosecution in that case maintained that the inhumane treatment of Jews and political opponents *in Germany* before the war constituted crimes against humanity. The Tribunal said in this connection--

> "With regard to crimes against humanity there is in doubt whatever that political opponents were murdered in Germany before the war, and that many of them were kept in concentration camps in circumstances of great horror and cruelty. The policy of terror was certainly carried out on a vast scale, and in many cases was organized and systematic. The policy of persecution, repression, and murder of civilians in Germany before the war of 1939, who were likely to be hostile to the government, was most ruthlessly carried out. The persecution of Jews during the same period is established beyond all doubt."[2]

The Tribunal was there speaking exclusively of crimes by Germans against Germans. It held that such acts were not crimes against Humanity, as defined by the Charter, not because they were crimes against Germans, but because they were not committed in execution of, or in connection with, aggressive war. Indeed, the Tribunal went on to hold that the very same acts committed after the war began were crimes against humanity. No distinction was drawn between the murder of German Jews and Polish or Russian Jews. And, moreover, no distinction was drawn between criminal medical experimentation on German and non-German concentration camp inmates or the murder of German and non-German civilians under the Euthanasia program. The Tribunal held them all to be war crimes and/or crimes against humanity.

[2] Ibid.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D.,
ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D.,
and PETER SHALIT, M.D., Ph.D.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN NURSES ASSOCIATION, AND THE AMERICAN PSYCHIATRIC ASSOCIATION, *ET AL.* AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTRODUCTION AND INTEREST OF *AMICI*

The right to control one's medical treatment is among the most important rights that the law affords each person. The associations of health care professionals that are submitting this brief strongly support the recognition and enforcement of that right. Health care professionals are committed to their ethical and legal obligations to honor patient requests to withhold or withdraw unwanted life-prolonging treatment and to provide patients with all medication necessary to alleviate physical pain, even in circumstances where such medication might hasten death. Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process.

The decision below, however, takes the unprecedented step of announcing a constitutional right to control the timing and manner of one's death through the use of physician-assisted suicide. The court of appeals would confer upon health care professionals the awesome responsibility of deciding who, among the many patients who would request physician-assisted suicide, are eligible to obtain the assistance of a physician in killing themselves. The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing. It is a power that most health care professionals do not want and could not control. Once established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, for whom physician-assisted suicide rather than good palliative care could become the norm. At greatest risk would be those with the least access to palliative care—the poor, the elderly, and members of minority groups.

The American Medical Association ("AMA"), the American Nurses Association ("ANA"), the American Psychiatric Association ("APA"), and 43 other national specialty and state medical societies that are submitting

this brief [1] represent hundreds of thousands of health care professionals who care each day for millions of Americans. Our members have deep compassion for those who are suffering the pain and torment of chronic or terminal illness. We have learned much in recent years about palliative care. Our experience is that a desire for physician-assisted suicide does not persist in patients who receive good palliative care.

Amici acknowledge that many patients today do not receive proper treatment for their pain, depression, or psychological distress. Nevertheless, physician-assisted suicide is not the right answer to the problem of inadequate care. Although for some patients it might appear compassionate intentionally to cause death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death. Rather than recognize a right to physician-assisted suicide, our society instead should recognize the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all.

To explain more fully the bases for *amici*'s position, we begin with a discussion of important aspects of caring for seriously ill patients who request physician-assisted suicide that were misapprehended by the court below.

HEALTH CARE BACKGROUND

The core of the Ninth Circuit's opinion is its view that each individual has a fundamental liberty interest "in choosing the timing and manner of one's death." Pet. App. A-21. While the phrase is superficially appealing, it belies the sad reality that none of us has the power completely to control the circumstances of our death. Illness, itself only one potential cause of death, comes

[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Court. A brief description of each *amicus* appears in Appendix A to this brief.

unbidden and with unpredictable effect. The Ninth Circuit's argument thus rests, at bottom, on an unrealistic assumption about our ability to control death.

At the same time, the Ninth Circuit overlooked the degree to which—without resorting to physician-assisted suicide—patients already can control aspects of the dying process. By recognizing patients' rights to refuse unwanted medical treatment or to have such treatment withdrawn, and by providing adequate pain relief, the health care professions have the capacity to prevent a prolonged and painful dying process. While much more remains to be done to ensure that all patients have access to good palliative care and effective advance care planning, see page 15, *infra*, experience to date shows that properly trained health care professionals can effectively meet their patients' needs for compassionate end-of-life care without acceding to requests for suicide.

A. Commitment To Patient Autonomy

The health care professions' ethical commitment to the principle of patient autonomy plays a vital role in providing patients with the ability to control their course of treatment. This commitment is expressed, for example, in Opinion 2.20 of the AMA Code of Medical Ethics. Opinion 2.20 provides, in part, that "[t]he principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity." AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* § 2.20 (App. 11a-12a); see also ANA, *Code for Nurses with Interpretive Statements* § 1.1 (App. 19a) (patients "have the moral right to determine what will be done with their own person" and "to accept, refuse, or terminate treatment without coercion").

Opinion 2.20 has great significance for patients near the end of life. To those who fear unwanted medical intervention in the dying process, the message of Opinion 2.20 is that a patient need not accept, and physicians must

not impose, a medical treatment that the patient does not want. As a practical matter, this means that a patient can refuse not only mechanical interventions such as respirators, feeding tubes, or dialysis, but also chemotherapy, antibiotics, or any other treatment that would have the effect of prolonging the patient's life. App. 12a. Through such means, persons suffering from chronic diseases (such as multiple sclerosis or amyotrophic lateral sclerosis) as well as terminal diseases can plan with their physicians which life-sustaining treatment to accept.

Opinion 2.20 unequivocally establishes that "[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care" and, significantly, that this obligation "includes providing palliative treatment even though it may foreseeably hasten death." App. 13a; see also App. 19a-20a (ANA Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients). Although criticized by the Ninth Circuit as illogical, the recognition that physicians should provide patients pain medication sufficient to ease their pain, even where that may serve to hasten death, is vital to ensuring that no patient suffer from physical pain.

The principle of patient autonomy, however, has never been understood to give patients the right to every procedure or treatment they might demand. For example, physicians need not provide futile treatment—that is, treatment that has no reasonable chance of helping the patient. *Code of Medical Ethics* § 2.035 (App. 15a). Similarly, physicians should not provide patients with treatments that are known to be ineffective or harmful. Such limitations are important. If a patient may demand and receive anything from a health care professional, individuals who practice the healing arts will cease being professionals.

B. Physician-Assisted Suicide

Long viewed as outside the realm of legitimate health care, physician-assisted suicide occurs "when a physician

facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act." *Code of Medical Ethics* § 2.211 (App. 11a); AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide*, 10 Issues in L. & Med. 91, 92 (1994). The practice involves physicians intentionally providing patients with the means for suicide, such as prescribing barbiturates in an amount certain to cause death and for the purpose of causing death. See, *e.g.*, Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691 (1991).

The ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. Its roots are as ancient as the Hippocratic Oath that a physician "will neither give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect," and the merits of the ban have been debated repeatedly in this nation since the late nineteenth century. Most recently, the AMA has reexamined and reaffirmed the ethical prohibition against physician-assisted suicide in 1977, 1988, 1991, 1993, and 1996.[2] Physician-assisted suicide remains "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Code of Medical Ethics* § 2.211 (App. 11a). Other health care professions have similar tenets. See, *e.g.*, App. 19a (ANA Position Statement on Assisted Suicide). Physicians and nurses have the ability to respond sensitively to the concerns of seriously ill and dying patients and can meet their patients' needs without acceding to requests for suicide.

C. Requests for Physician-Assisted Suicide

The Ninth Circuit's decision rests in substantial part on the assumption that there are a "growing number of termi-

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[2] AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 477 (1996). Most recently, in the aftermath of the decision below, the AMA's House of Delegates in June 1996 overwhelmingly endorsed a recommendation to affirm the ban on physician-assisted suicide.

nally ill patients who die protracted and painful deaths," Pet. App. A-53, and who, absent physician-assisted suicide, are condemned to face "unmitigated torture" before they die. Pet. App. A-106. Implicit in the court's holding are the views that those who request suicide do so to avoid excruciating pain, and that health care professionals can do nothing compassionate in response other than to assist in suicide. The court cited no evidence to support these views. In fact, available information demonstrates that these views are misguided.

1. There is no evidence that increasing numbers of patients are dying in severe pain. To the contrary, "[t]he potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts." AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996). The pain of most terminally ill patients can be controlled throughout the dying process without heavy sedation or anesthesia. *Id.*; see, *e.g.*, Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Pall. Care 25, 26 (1993); Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symp. Mgmt. 289 (1991); Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124 (1996). For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain. N.Y. State Task Force, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 & n.21 (1994). Notably, when pain medication is properly administered, for most patients the risk of respiratory depression that hastens death is minimal. N.Y. State Task Force at 162.

Given the increasing ability to control pain, it is not surprising that, contrary to the Ninth Circuit's assumption, the demand for physician-assisted suicide does not come principally from those seeking relief from physical pain.

A recent study of such requests in Washington State found that "neither severe pain nor dyspnea was a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia." Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996). This finding is consistent with a report from Compassion-in-Dying, see Preston & Mero, *Observations Concerning Terminally Ill Patients Who Choose Suicide*, 4 J. Pharm. Care & Pain Symp. Control 183, 187 (1996) ("[i]n no patient was pain the primary reason for suicide"); with other studies of patients and physicians, see Emanuel *et al.*, *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1809 & nn.6, 12 (1996) ("[p]atients experiencing pain were not inclined to euthanasia or physician-assisted suicide"); as well as with studies of Holland's experience, see Van der Maas *et al.*, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669, 672 (1991) (relief from pain was mentioned as a factor in fewer than half of cases, and was the sole factor in only five percent of cases).

This is not to say that all patients have access to and actually receive adequate pain relief and good palliative care. They do not. The delivery of such care is "grossly inadequate" today, and efforts to make such care universally available have not yet succeeded. N.Y. State Task Force at 43-47; Connors *et al.*, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). There are many obstacles to the delivery of adequate pain management. These include a lack of professional training and knowledge, misconceptions about the risks of addiction and respiratory depression associated with pain medication, inadequate communication (reflecting both inadequate attention from health care professionals and undue reluctance of patients and their families to use pain relief medication), and concern over criminal or licensure actions against the prescribing physicians. N.Y. State Task Force at 44-47; AMA Council,

275 JAMA at 476. Of further concern, individuals treated at centers that serve predominantly minority patients are more likely than others to receive inadequate pain treatment; the same is true for elderly and female patients. N.Y. State Task Force at 44 & n.37. Yet for "many patients, pain and suffering could be alleviated using medications and techniques that have been widely publicized and require only modest resources." *Id.* at 35. There is, in short, compelling evidence of the need to ensure that all patients have access to quality palliative care, but not of any need for physician-assisted suicide in order to control pain.

2. Most patients that request suicide do so out of concerns that, in the future, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families. Back *et al.*, 275 JAMA at 921; Emanuel *et al.*, 347 Lancet at 1807. The suffering that such concerns may cause is real. But if the anticipatory and existential nature of that suffering is recognized and addressed, it can often effectively be alleviated. Foley, 6 J. Pain & Symp. Mgmt. at 289-90; N.Y. State Task Force at x, 181.

Concerns about future loss of control, loss of dignity, or pain frequently can be met by reassuring the patient of a continuing commitment to attentive comfort care and by assisting the patient to confront an underlying and unspoken fear of death. "Many patients and physicians displace anxieties about death onto the circumstances of dying: pain, dependence, loss of dignity, and the unpleasant side effects of medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself." Hendin, *Suicide, Assisted Suicide, and Euthanasia: Lessons from the Dutch Experience*, Summary of Testimony Presented to House Subcommittee on the Constitution 1 (1996). A full approach to palliative care addresses spiritual and existential feelings as well as personal and social burdens, using a team approach that draws on social workers and pastors as well as physicians and

nurses. Clinicians with experience assisting dying patients to confront such concerns report that the desire for death passes, and that patients say they have found unexpected meaning in their lives that makes their final days worth living. *E.g.*, Cundiff, *Euthanasia Is Not the Answer* 29-39 (1992).

The anxieties that can accompany serious illness are often complicated, however, by the onset of depression. Depression is the single factor found to be a significant predictor of the desire for death. Emanuel *et al.*, 347 Lancet at 1809; Chochinov *et al.*, *Desire for Death in the Terminally Ill*, 152 Am. J. Psych. 1185, 1190 (1995). In one study of 44 terminally ill patients, all but one of the eleven patients with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. Brown *et al.*, *Is it Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psych. 208, 210 (1986); see also Conwell & Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 New Eng. J. Med. 1100, 1101 (1991) ("of 44 patients in the later stages of cancer, only 3 had considered suicide, and each of them had a severe clinical depression"); AMA Council, 275 JAMA at 475; Chochinov *et al.*, 152 Am. J. Psych. 1185. In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which generally is treatable. Hendin, *Suicide and the Request for Suicide: Meaning and Motivation*, 35 Duq. L. Rev. 285, 285 (1996); N.Y. State Task Force at 13, 180.

It is clear that "a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." Chochinov *et al.*, 152 Am. J. Psych. at 1190. For example, "[t]he elderly appear to be more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to available, modern treatments." Conwell & Caine, 325 New Eng. J. Med. at 1101. Nevertheless, most physicians fail to recog-

nize depression, thereby precluding the opportunity for effective treatment. *Id.* at 1101-02.

3. The demand for physician-assisted suicide among the terminally ill is thus best understood not as a necessary response to untreatable pain uniquely felt by the dying, but in the broader context of requests for suicide generally. "Among all suicides, only two percent to four percent are terminally ill." N.Y. State Task Force at 12. Moreover, while severe chronic or terminal illness is a risk factor for suicide, "only a small percentage of terminally ill or severely ill patients attempt or commit suicide." *Id.* at 9, 13. And those patients are similar to physically healthy individuals who contemplate suicide—they "are usually suffering from a treatable mental illness, most commonly depression." *Id.*

Thus, contrary to the Ninth Circuit's most basic premise, terminal illness does not present a special case for physician-assisted suicide. Patients with chronic or terminal illness who seek physician-assisted suicide are typically depressed or anticipating extreme suffering. Their needs and concerns are ones that health care professionals can meet with compassionate care. There may be, even in a system that provides optimal palliative care to all patients, individuals whose pain may not be treatable absent sedation and whose wish for physician-assisted suicide to avoid sedation is sincere. But the number of such individuals is likely to be very small, and the social cost of accommodating their preference for physician-assisted suicide over sedation and withdrawal of treatment is likely to be high. For reasons that follow, even if physician-assisted suicide were thought appropriate for such patients, no one can predict with any confidence that physician-assisted suicide, if authorized by the state, could reliably be limited to them.

D. The Inherent Difficulty In Regulating Physician-Assisted Suicide

Proponents of physician-assisted suicide agree that lines must be drawn between categories of individuals for

whom physician-assisted suicide is to be deemed acceptable or unacceptable. The Ninth Circuit permitted physician-assisted suicide for those with a "terminal illness." Pet. App. A-113 to A-114. In *Vacco* v. *Quill*, No. 95-1858, the Second Circuit purported to restrict physician-assisted suicide narrowly to those who were "in the final stages of terminal illness." Pet. App., No. 95-1858, at 4a. Both courts expressly limited their holdings to the provision of physician-assisted suicide (Pet. App., No. 95-1858, at 32a-34a & n.3; Pet. App. A-104), but the Ninth Circuit candidly expressed its doubt that any reasonable distinction could be maintained between physician-assisted suicide and voluntary euthanasia. Pet. App. A-100. The "critical line," the Ninth Circuit stated, was between the "voluntary and involuntary termination of an individual's life." *Id.*

The Ninth Circuit declared that "while there is always room for error in any human endeavor, we believe that sufficient protections can and will be developed by the various states." Pet. App. A-103 to A-104. As two commenters note, however: "Where? Which state has done so? In its 153-page opinion, not once does the Ninth Circuit attempt to show how this might be accomplished." Callahan & White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 83 (1996). Existing rules limiting physician-assisted suicide are not being followed today. AMA Bd. of Trustees, *Euthanasia/Physician-Assisted Suicide: Lessons in the Dutch Experience*, 10 Issues in L. & Med. 81 (1994). For example, the study of euthanasia and physician-assisted suicide commissioned by the Dutch government showed that approximately one in four cases of euthanasia did not qualify as voluntary under the guidelines. Van der Maas *et al.*, 338 Lancet at 671; Kass & Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 412-13 & nn.29-30 (1996). Different social circumstances in the United States make effective regulation even less likely here than in Holland. See AMA Bd. of Trustees, 10

Issues in L. & Med. at 88-89. Difficulties inherent in the regulation of physician-assisted suicide suggest that even strenuous efforts to regulate such a practice will not succeed.

1. One proposed restriction is to limit physician-assisted suicide to those in the last stages of a terminal illness. An initial difficulty arises, however, in identifying the eligible class. Available evidence suggests "that physicians' predictions of expected remaining life are generally inaccurate." Callahan & White, 30 U. Rich. L. Rev. at 46 & n.202. For example, while admission to hospice is contingent on a diagnosis of six or fewer months to live, a recent study showed that 15 percent of hospice patients survived longer than six months and eight percent survived longer than one year. Christakis & Escarce, *Survival of Medicare Patients after Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172 (1996); see Lynn *et al.*, *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996). Life expectancy is thus inherently problematic as a criterion for establishing eligibility to exercise a constitutional right.

The lack of clear-cut lines between those who are terminally ill and those who are in the last stages of a terminal illness suggests that any attempt to limit the availability of physician-assisted suicide to the latter would be arbitrary. But the same is true for the line between the terminally ill and the chronically ill. No one can confidently say that the degree of pain or suffering experienced by a person in the last stages of a terminal disease is greater than that experienced by someone at an earlier stage of terminal illness, or by someone who is chronically ill. Moreover, if the pain or suffering is thought to be irremediable, then the longer the patient's life expectancy, logically the more pain and suffering awaits the patient. Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 737, 740-41 (1995). There would thus be little to prevent expansion of physician-assisted suicide beyond the confines of the last stages of terminal illness.

The experience in the Netherlands illustrates the difficulty of hewing to particular guidelines. Physician-assisted suicide and euthanasia remain unlawful but are not prosecuted if performed by a physician in accordance with established procedures. Keown, "Some Reflections on Euthanasia in the Netherlands," *in Euthanasia, Clinical Practice and the Law* 193, 197 (Gormally ed., 1994). In one recent, much-discussed case, a physician, who assisted in the suicide of a physically healthy, 50-year-old woman who sought death in the aftermath of the death of her two sons, was acquitted by a three-judge court in Assen of charges that he had violated the Dutch procedures. The Assen case is significant in that it "marked Dutch acceptance of depressed suicidal patients as eligible for assisted suicide or euthanasia," Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 Issues in L. & Med. 123, 129 (1994), and thereby demonstrated the difficulty of restricting the availability of physician-assisted suicide even to those with a physical illness.

2. There are also formidable obstacles to restricting physician-assisted suicide only to those patients who voluntarily request it. First, the fact that many patients do not receive adequate pain relief or suffer from undiagnosed and untreated depression puts undue pressure on them to seek physician-assisted suicide. A substantial percentage of elderly patients suffer mental confusion that also routinely goes undiagnosed. Francis *et al.*, *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097 (1990). Moreover, poor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide.

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and fam-

ilies need. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 Duq. L. Rev. 455 (1996). These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel. As the Chief of the Pain Service at Memorial Sloan-Kettering Cancer Center reports, "[w]e comonly see [requests for physician-assisted suicide] dissolve with adequate control of pain and other symptoms." Foley, 6 J. Pain & Symp. Mgmt. at 290.

Providers willing to comply with requests for suicide may be among those least sensitive to the impact of these pressures and least familiar with alternative responses to their patients' needs. A recent study shows that support for physician-assisted suicide was highest among those health care professionals least knowledgeable about pain symptom management and least capable (due to emotional exhaustion) of empathizing with the patient. Portenoy *et al., Determinants of the Willingness to Endorse Assisted Suicide: A Survey of Physicians, Nurses, and Social Workers*, —— Psychosomatics —— (forthcoming April 1997); see also Bachman *et al., Attitudes of Michigan Physicians and the Public toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 New Eng. J. Med. 303, 308 (1996) ("doctors who had the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide"). There is thus added reason to doubt that patients seeking physician-assisted suicide would receive adequate palliative care before such a request is granted.

Second, separating the wishes of the patient from those of the family is extremely problematic. One of the most common reasons why patients request suicide is to spare their families and loved ones the burdens and expense of caring for them. See, *e.g.*, Blendon *et al., Should Physicians Aid their Patients in Dying?*, 267 JAMA 2658, 2660-61 (1992); Emanuel, *Cost Savings at the End of Life: What Do the Data Show?*, 275 JAMA 1907 (1996). But to what extent are these feelings the result of the family's expectations? In one recent study, families of elderly, terminally ill patients were significantly more

likely than the patients themselves to express support for physician-assisted suicide. Koenig *et al., Attitudes of Elderly Patients and Their Families toward Physician-Assisted Suicide*, 156 Arch. Int. Med. 2240, 2244 (1996). Families, especially when confronted with the expense and burden of caring for a terminally ill family member, may be beset with conflicting feelings about hastening a family member's death, as recent cases vividly illustrate. *E.g.*, "Countdown to a Suicide," *The New York Times*, Dec. 20, 1995, at A-20 (Delury case). Even those family members consciously committed to preserving their loved one's sense of dignity and autonomy may needlessly acquiesce in or encourage a suicide that could be avoided by assuring the patient that, in their eyes, illness has not compromised his or her dignity. Byock, "Physician-Assisted Suicide Is *Not* an Acceptable Practice for Physicians," *in Physician-Assisted Suicide: Ethical Positions, Medical Practices, and Public Policy Options* —— (Weir ed., forthcoming May 1997).

Third, experience to date provides little basis for confidence that health care professionals can reliably determine whether patients have provided truly informed consent for assisted suicide. Frank, sensitive, and extended conversations between physicians and patients are presumptively antecedents to such a determination. Such conversations would be infinitely more complex than any that regularly occur today. For example, ineffective communication remains a major obstacle to achieving pain management, American Pain Society Quality of Care Committee, *Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain*, 274 JAMA 1874, 1874 (1995), even though pain relief is plainly a goal shared by both health care professionals and patients. And despite their importance, discussions about advance care planning are rare and poorly handled, which hampers effective and responsive end-of-life care. Emanuel, "Advance Directives," *in Principles and Practice of Supportive Oncology* —— (Berger *et al.* eds., forthcoming 1996).

The well-established phenomena of transference and countertransference further complicate the problem of

relying upon physicians and nurses to identify voluntary requests. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994). Particularly when caring for chronically ill, dying, or suicidal patients, caregivers often have "difficulty tolerating such patients' dependency." *Id.* at 1786 (footnote omitted). Their "feelings of frustration and inadequacy occasioned by irreversible medical problems" sometimes lead them "to withdraw from such patients or see them as hopelessly or rationally suicidal" when in fact they are not, which "in turn may precipitate suicides." *Id.* As one physician with extensive experience caring for dying patients has observed, "[o]nly because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying." Miles, *quoted in* Kass & Lund, 35 Duq. L. Rev. at 418.

Health care professionals also experience great frustration at not being able to offer the patient a cure. For some, the ability to offer the patient the "treatment" of assisted suicide may provide a sense of "mastery over the disease and the accompanying feelings of helplessness." Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 129. This may cause health care professionals or a patient's family to endorse and reinforce requests for suicide more readily than the patient's own ambivalent feelings would warrant. Miles, 271 JAMA at 1786. Published accounts of physician-assisted suicide reveal that even those physicians who consciously seek only to implement a patient's voluntary request overlook ways in which their recommendation and support of physician-assisted suicide reinforced the patient's decision for death and left unexamined indications that the patient really did not want to die. Hendin, *Selling Death and Dignity*, 25 Hast. Ctr. Rep. 19 (1995); Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 125-29.

3. The obstacles to identifying and restricting physician-assisted suicide to those patients who meet criteria of terminality and voluntariness are not likely to be overcome simply by devoting more resources to oversight of

treatment decisions. Indeed, the unprecedented intrusion into the physician-patient relationship needed independently to regulate such treatment decisions would be fundamentally inconsistent with the private nature of health care treatment, and all too likely to undermine what progress has been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control. Callahan & White, 30 U. Rich. L. Rev. at 67, 80.

Transforming physician-assisted suicide into a medical procedure would create momentum in favor of its use that regulation could not reverse. Were physician-assisted suicide to become a legitimate medical option, then a decision not to select that option would make many patients feel responsible for their own suffering and for the burden they impose on others. Once a patient can choose physician-assisted suicide, it is but a short step to ask a patient why he or she has not done so. Indeed, it seems likely the patient would feel pressure to revisit the question repeatedly, perhaps every day. Many patients thus will "experience—and be helped [by their families or physicians] to experience—their right to choose physician-assisted death as a *duty* to do so." Kass & Lund, 35 Duq. L. Rev. at 407.

SUMMARY OF ARGUMENT

In announcing that the Due Process Clause affords every individual "a liberty interest in choosing the timing and manner of one's death" (Pet. App. A-21), the Ninth Court was moved by the condition of the individual patients seeking judicial relief. The court of appeals failed, however, to examine the broader context in which these patients acted and the circumstances of many other patients who will be affected by its judgment. It also failed to articulate a persuasive constitutional or moral basis for invalidating these longstanding laws. The ancient prohibition on physician-assisted suicide reflects a deeply rooted antipathy to the intentional taking of human life, even when described as "mercy killing." None of the decisions of this Court cited below establishes a basis in the Constitution for invalidating state laws that maintain this prohibition.

Moreover, even if a liberty interest in committing suicide were recognized, the interests of states in adhering to the prohibition against physician assistance have grown, if anything, stronger in recent years. Advances in palliative care make it possible to control most patients' pain without resort to heavy sedation, and further improvements in the provision of appropriate pain relief and compassionate end-of-life care will happen. In acting precipitously to declare a constitutional right to physician-assisted suicide, the Ninth Circuit's judgment may slow the momentum of such efforts. This Court should refrain from a constitutional ruling that "may be fraught with serious consequences to the nation." *New State Ice Co.* v. *Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

ARGUMENT

THIS COURT'S DUE PROCESS JURISPRUDENCE DOES NOT PROVIDE A BASIS FOR FINDING A CONSTITUTIONAL LIBERTY INTEREST IN OBTAINING A PHYSICIAN'S ASSISTANCE TO COMMIT SUICIDE.

As a constitutional matter, neither this Court's jurisprudence nor any other legal principle supports the inference of a novel and potentially harmful right to physician-assisted suicide. The prohibition against physician-assisted suicide serves a vital social function that, once lost, will result in incalculable and severe damage to patients and to the health care profession.

A. The Individual's Fourteenth Amendment Liberty Interest In Refusing Medical Treatment Does Not Encompass The Right To Physician Assistance In Committing Suicide.

In finding a liberty interest in controlling the timing and manner of one's death, the Ninth Circuit relied initially upon this Court's decision in *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990). Pet. App. A-61. The *Cruzan* case concerned the plight of Nancy Cruzan, who, at the age of 25, suffered an automobile accident that left her permanently unconscious,

existing in what is termed a persistent vegetative state. She was kept alive by means of a surgically implanted feeding tube for six years after the accident, during which time she never regained consciousness. 497 U.S. at 266. When it became clear that Nancy's condition would never improve, her parents, seeking to implement the treatment decision they believed she would have made, sought to discontinue life support functions. *Id.* at 268.

Cruzan thus presented the Court with the profoundly difficult question of whether and in what manner a state could refuse to honor the request of an incompetent patient's surrogate that life support functions be discontinued. In a careful and narrowly drawn opinion, the Court suggested that "the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest," but that "the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible." *Id.* at 279. The Court then upheld the State of Missouri's requirement that an incompetent patient's wish to cease treatment be proved by clear and convincing evidence. *Id.* at 280-82.

The liberty interest discussed in *Cruzan* is grounded in the common law protection afforded to every person to refuse unwanted medical treatment. *Id.* at 269-70. Medical treatment performed without the patient's consent historically has been treated as a battery, excusable only in emergency circumstances. *Id.* at 270; Keeton *et al., Prosser and Keeton on the Law of Torts* 39-42, 190 (5th ed. 1984); *Winters* v. *Miller*, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). The right to refuse treatment is the "logical corollary" of the prohibition against medical treatment without the patient's informed consent. *Cruzan*, 497 U.S. at 270. These principles constitute fundamental tenets of the health care professions and are readily embraced by *amici* as a matter of both common law and constitutional right.

Physician-assisted suicide does not involve the imposition of treatment against the patient's will. It involves instead the furnishing of assistance that is (at least in theory) desired by the patient. Thus, the rationale that unwanted medical treatment can be refused because it amounts to a common law assault and battery provides no legal or logical basis for finding a right to physician-assisted suicide.

In other contexts, courts, including this one, have been reluctant to find a right to obtain medical treatment. See *New York State Opthalmological Soc'y* v. *Bowen*, 854 F.2d 1379, 1389-92 (D.C. Cir. 1988), *cert. denied*, 490 U.S. 1098 (1989); *cf. United States* v. *Rutherford*, 442 U.S. 544 (1979) (terminally ill cancer patients not entitled to a drug that has not been approved by the Food and Drug Administration). *Amici* believe there should be constitutional protection for the "freedom to determine the course of [one's] own treatment." *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring). The assistance sought in this case, however, is to a procedure that neither state law nor the medical profession has ever considered to be a legitimate medical treatment. It would be particularly ironic, therefore, if the first "treatment" to which patients were held to have a constitutional right were physician-assisted suicide.

The Ninth Circuit also relied upon broader linguistic formulations of the sources of the right to refuse treatment, such as the "right to be let alone," *Olmstead* v. *United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), or the right of every adult "to determine what shall be done with his own body," *Schloendorff* v. *Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.). These formulations are rightly looked to as indicative of the importance and centrality of the autonomy principle. But the paradox of invoking autonomy as justification for killing oneself has long been noted.[3] And

[3] Whether the principle of autonomy can support a right to take one's life is an issue on which eminent philosophers disagree. *See, e.g.*, N.Y. State Task Force at 81 (contrasting Kant's view that "taking one's own life was inconsistent with the notion of autonomy" with Hume's view that "when life is most plagued by suffering, suicide is most acceptable"). Surely, given a choice between Kant and Hume, the Constitution allows state legislatures, and not federal courts, to make the decision.

in practice, the principle has never been interpreted as sweepingly as the Ninth Circuit proposes. *Cruzan* itself alluded to the limits of the autonomy principle, noting that the consequences of a particular procedure "would inform the inquiry" as to whether treatment can be refused. 497 U.S. at 279. This Court has repeatedly recognized other limits as well. For example, laws prohibiting prostitution or use of illicit drugs, or mandating vaccinations or blood tests, have never been considered constitutionally infirm. See, *e.g.*, *Washington* v. *Harper*, 494 U.S. 210, 221-22 (1990) (state may administer antipsychotic medicine to mentally ill prisoner over his objection); *Jacobson* v. *Massachusetts*, 197 U.S. 11, 24-30 (1905) (state may require vaccinations because Fourteenth Amendment "does not import an absolute right" to be "wholly freed from restraint"); *Schmerber* v. *California*, 384 U.S. 757 (1966) (police may perform alcohol-blood test of suspect over his objection); *Breithaupt* v. *Abram*, 352 U.S. 432, 439 (1957) (same); *cf. Employment Div.* v. *Smith*, 494 U.S. 872, 878 (1990) (state may prohibit use of peyote even as part of religious ritual). Accordingly, the principle of bodily integrity, while of central and vital importance, does not in itself justify a constitutional right to physician-assisted suicide.

B. Physician-Assisted Suicide Lies Outside The Continuum Of Liberty Interests That This Court Has Previously Recognized As Constitutionally Protected.

1. The Ninth Circuit also relied more broadly on the balance of this Court's due process jurisprudence. Heightened judicial protection is provided for some rights that have no textual support in the Constitution if they are "implicit in the concept of ordered liberty," such that

"neither liberty nor justice would exist if they were sacrificed." *Palko* v. *Connecticut*, 302 U.S. 319, 325-26 (1937). These liberties, which are "deeply rooted in this Nation's history and tradition," *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (footnote omitted), may be located on a "rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . ." *Poe* v. *Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting); see Pet. App., No. 95-1858, at 17a-18a (identifying previously recognized rights).

Asserted rights that are absent from both the text of the Constitution and the traditions of our nation lie at the furthest edge of the continuum. *Moore*, 431 U.S. at 503. And the constitutional stature of conduct that has long been prohibited by state law is even more tenuous. Physician-assisted suicide is not a right that our society historically has protected against state interference. Both suicide and attempted suicide were unlawful under the Common Law of England and the laws of the colonies. See 4 Blackstone, *Commentaries on the Laws of England* 89 (1978); Marzen *et al.*, *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 56-57 (1985). Although all states have chosen to decriminalize both suicide and attempted suicide, 35 states continue to proscribe assisting in another's suicide, and eight other states prohibit it as a common law crime. 2 Meisel, *The Right to Die* § 18.17, at 478 Table 18-1 (2d ed. 1995). This long-standing governmental and societal antipathy to aiding in a suicide, while perhaps not conclusive, counsels strongly against finding the liberty interest urged by respondents here.[4]

2. Nevertheless, the Ninth Circuit identified a right to physician-assisted suicide by relying heavily upon *Planned*

[4] Although the Ninth Circuit relied on survey data to suggest a change in popular views, Pet. App. A-48 to A-49, it cited no reason why popular preferences could not be vindicated through changes in state law by the political branches.

Parenthood v. *Casey*, 505 U.S. 833 (1992). In *Casey*, the Court reaffirmed that women have a constitutionally protected liberty interest in obtaining an abortion that states may not unduly burden. 505 U.S. at 869. In so holding, the Court stated that abortion was akin to "personal decisions relating to marriage, . . . child rearing, and education," which involve "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy," and which are "central to the liberty protected by the Fourteenth Amendment." *Id.* at 851. The Court further stated that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.* From this, the Ninth Circuit concluded that a right to physician-assisted suicide falls within the ambit of personal liberty protected by the Fourteenth Amendment.

Casey and this Court's other substantive due process decisions should not be read so broadly. *First*, whatever interpretation the quoted language may bear in the abstract, its meaning ought not be understood apart from its context. *Casey* narrowly reaffirmed an existing liberty interest principally on grounds of *stare decisis*. And while the more sweeping argument that the Due Process Clause creates a broad realm of autonomy in making personal choices has been made to the Court on a number of occasions, the Court has never embraced this principle in this open-ended form. See, *e.g.*, *Cruzan*, 497 U.S. at 279 n.7. Presumably this is because, read broadly, the quoted language would encompass not simply the decisions of the terminally ill, but a broad range of decisions, including any person's choice to terminate his or her life at any time. See Pet. App. A-28 to A-29. Thus, for example, a depressed 25-year-old, who has not received appropriate psychiatric treatment, would have a liberty interest in obtaining assistance in committing suicide. As discussed above, such a right has never been recognized by this Court, by any courts at common law, or indeed, by respondents.

Second, as a factual matter, a woman's right to choose to have an abortion differs materially from a patient's right to physician-assisted suicide. In the physician-assisted suicide context, the procedure at issue has no life- or health-promoting benefits whatsoever; its sole function is to achieve the death of the patient. In the abortion context, however, the procedure itself is medical and cannot be performed by an unqualified person without extreme risk of permanently injuring or killing the woman. It is instructive in this regard to recall the Court's recognition in *Roe* v. *Wade*, 410 U.S. 113, 163-64 (1973), that the state has a compelling interest in preserving the fetus once the fetus is viable. Neither *Roe* nor *Casey* authorizes any person to assist in killing an independent human life.

Third, Casey rests in substantial measure on the recognition that undue obstacles to obtaining an abortion, by restricting a woman's "ability to control [her] reproductive li[fe]," compromise her "ability to participate equally in the economic and social life of the Nation." *Casey,* 505 U.S. at 856. Preserving the right of choice prevents the state from imposing "its own vision of women's role" in society. *Id.* at 852. The Court's explicit recognition of this dimension of the right to choice makes clear that the *Roe* and *Casey* decisions must be understood as grounded in part on the need to afford women liberty to participate in society equal to that of men. Others of this Court's privacy decisions have also served to invalidate similar discriminatory legislation.[5] No comparable rationale applies to physician-assisted suicide.

[5] Thus, the Court's decision in *Loving* v. *Virginia*, 388 U.S. 1 (1967), struck down a ban on interracial marriage that not only invaded the right to marital privacy but perpetuated discrimination against black Americans. Similarly, the decision in *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), removed the heavy burden that lack of access to birth control placed on women's social, economic, and political opportunities. *Cf. Romer* v. *Evans*, 116 S. Ct. 1620, 1625 (1996). Terminal illness and death, by contrast, do not discriminate, and laws prohibiting physician-assisted suicide have no disproportionate impact upon any particular class of historically disadvantaged individuals. To the contrary, the risk that physician-assisted suicide will occur more frequently among disadvantaged patients should counsel restraint in constitutionalizing the issue.

Finally, in contrast to other liberty interests previously recognized by this Court, the liberty interest asserted here is unique in that the state concededly has compelling reasons to prohibit its exercise by most who would seek to invoke it. To begin with, the right to control the timing and manner of one's death is not limited to "physician-assisted suicide" for "terminally ill competent adults who wish to hasten their deaths with medication prescribed by their physicians." Pet. App. A-113 to A-114. The Ninth Circuit acknowledged that this formulation of the right was only a starting point, and that the right was likely to be broadened over time. Without resolving the issue, the Ninth Circuit signalled that it was likely in the future to invalidate any proposed distinction between physician-assisted suicide and voluntary euthanasia for patients who could not carry out a suicide themselves. Pet. App. A-100 to A-101. And, while the Ninth Circuit did not directly acknowledge the problematic nature of restricting the right only to the terminally ill, the court did admit that, in its view, the critical dividing line was between voluntary and involuntary termination of life. *Id.* at A-100 & n.120. This admission reflects the fact that profound suffering that can prompt a request for suicide arises not simply in the terminally ill but in the chronically ill and physically healthy as well. *E.g.,* Kamisar, 72 U. Det. Mercy L. Rev. at 739.

At the same time, the Ninth Circuit recognized that physician-assisted suicide was unjustifiable for many people, and proposed to rely on states and the medical profession to develop procedural safeguards to prevent individuals that did not meet criteria from receiving assistance in committing suicide. Admission of the need for extensive regulation and safeguards to prevent most who would

seek to exercise this right from doing so is, however, strong reason to doubt that any such right can fairly be viewed as "implicit in the concept of ordered liberty." *Palko*, 302 U.S. at 325-26. It is inconsistent with the nature of a fundamental right that its exercise is so troubling and susceptible to abuse that extensive state regulation and proscription is justifiable. The admitted need for extensive state regulation also illustrates why, far from being an essentially "private" matter, physician-assisted suicide is a public act with wide-ranging and profound consequences for families, health care professionals, and society.

C. States Have Strong Interests In Prohibiting Physicians And Nurses From Assisting In Suicides.

Because all agree that the states have strong interests in regulating life-and-death decisionmaking, the salient question is where the Constitution permits the state to draw the line. *Amici* urge the Court to permit states to prohibit physician-assisted suicide outright. This approach is supported by at least three strong state interests.

1. First, states have an overwhelming interest in avoiding preventable suicides. For many reasons, a state could reasonably conclude that, once physician-assisted suicide is permitted for any class of patients, the number of patients committing suicide with the assistance of a physician will substantially increase no matter how narrowly the initial restrictions are drawn, and will involve patients in circumstances far removed from those surrounding the respondents.

To begin with, states could justifiably conclude that relatively few, if any, patients would ever legitimately meet the kind of strict criteria that a state might seek to impose in lieu of banning physician-assisted suicide outright. Most terminally ill patients do not raise the issue of physician-assisted suicide and, given advances in palliative care, it is unlikely that the needs of those who do raise the issue cannot be met through other means.

States could also reasonably conclude, however, that restrictions intended to limit physician-assisted suicide to a narrow class of patients would not work. The demand for physician-assisted suicide principally comes not from the patients in actual and untreatable pain at the very end of life, but from those, whether healthy, chronically ill, or terminally ill, who are depressed, or who fear future pain, loss of dignity, or unduly burdening their families. Once physician-assisted suicide becomes available, many patients whose needs could have been met through appropriate palliative care will instead be directed toward physician-assisted suicide. States could further conclude that the many pressures on patients that may lead to consideration of suicide would, if suicide were officially blessed as a medical treatment, exert powerful pressure on patients to accept suicide more as a duty than as a right.

In this regard, the requirement that such requests be deemed voluntary by one or more physicians is not likely to provide an effective safeguard. For example, terminally ill patients typically are highly dependent upon, and vulnerable to influence by, the very individuals—family and physician—who often have conflicting feelings about pursuing treatment options that could reduce the patient's desire for suicide. To pursue alternatives is to increase the likelihood of extending the patient's life and, necessarily, the obligation of caring for the patient. The family may, entirely unconsciously but nevertheless powerfully, find such an outcome acutely burdensome and therefore subtly encourage the patient to accept death and thereby promote the patient's interest in suicide. The physician is typically in no position to discern the operation of such pressures, and may have his or her own reasons for not attending to them. Absent the kind of due process safeguards that attend decisions by the state to terminate life, which are antithetical to the privacy of the physician-patient relationship, there is little likelihood that an inappropriate exercise of physician-assisted suicide will ever

come to light. *Cf. Bowen* v. *American Hosp. Ass'n*, 476 U.S. 610 (1986).

States also have a strong interest in drawing a defensible line. The one they now rely upon is well established in the common law and medical ethics. For example, although the provision of medication in doses strong enough to relieve pain typically will not bring about a patient's death, such a result can occur. As long as the physician's intent is to ease the patient's pain and not to cause death, the administration of such medication is ethical and fully consistent with a physician's role as healer. Indeed, the provision of such medication is in principle no different than the provision of chemotherapy that is intended to heal but could have the unintended effect of hastening death.

Although the Ninth Circuit criticized this doctrine of double effect, the doctrine's reliance upon intent is solidly grounded in principles of law and morality. Pet. App. A-163 (Kleinfeld, J., dissenting). The Ninth Circuit proposed no better alternative, and tacitly admitted that its own line was flawed. Pet. App. A-100 to A-101. Once physician-assisted suicide is recognized, how can the right to voluntary euthanasia be denied to those who lack the physical ability to administer the life-ending drug to themselves? And once such a right is recognized for those who are terminally ill, how can it be denied to those who, chronically ill or irremediably depressed, claim to be suffering comparably unendurable pain? Even the ultimate stopping point proposed by the Ninth Circuit—between voluntary and involuntary patient requests (*id.*)—is not secure. It rests on a determination of patient intent that is at least as problematic as the determination of physician intent. Thus, not only does the Ninth Circuit's line lack any basis in the common law, it is as vulnerable to the Ninth Circuit's own analysis as is the line states draw today.

2. Second, states can argue strongly that abandoning the prohibition on physician-assisted suicide will undermine efforts to expand the provision of palliative care to all patients. Although such efforts would not end if physician-assisted suicide were permitted, the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care. Permitting physician-assisted suicide would also jeopardize the hard-won advances firmly to establish for all patients a right not only to have unwanted medical treatment withheld or withdrawn but also to receive pain medication sufficient to ease pain, even if that would hasten the patient's death. The widespread acceptance of these rights by health care professionals, courts, legislatures, and the public depended upon the recognition and acceptance of the distinction between these rights and physician-assisted suicide. See generally 2 Meisel § 18.18, at 479-85. If that important boundary is lost, much support for withholding and withdrawing treatment or providing ample pain medication may be lost as well.

3. Finally, states have a strong interest in avoiding the damage to the health care professions and their ability to serve patients that would flow from an abandonment of the prohibition against physician-assisted suicide. *E.g., Semler* v. *Oregon State Bd. of Dental Examiners*, 294 U.S. 608, 612-13 (1935) (state's strong interest in "maintenance of professional standards" permits it to enforce "a general rule even though in particular instances there might be no actual" harm); *Ohralik* v. *Ohio State Bar Ass'n*, 436 U.S. 447, 460 (1978) (state interest in "maintaining standards among members of the licensed professions" is "particularly strong"); *Shapero* v. *Kentucky Bar Ass'n*, 486 U.S. 466, 485 (1988) (O'Connor, J., dissenting) (state "should have considerable latitude to ban" conduct that "undermines the substantial government interest in promoting the high ethical standards" of a profession). Health care professionals have long understood that with the right to practice comes enormous

responsibility. Patients come to physicans and nurses at times of greatest need and vulnerability, depending on them to respond to their needs capably and faithfully. Many patients may understandably wonder, finding themselves badly injured and in the care of a physician they do not know but whose license permits him or her to assist in taking the lives of patients, whether that physician will truly act only to preserve their lives. Will they be confident, as they watch a physician draw a dose of morphine, that the physician is committed only to easing their pain and not to taking their lives? See Kass & Lund, 35 Duq. L. Rev. at 408. The ban on physician-assisted suicide helps ensure that patients will never lose the trust that must exist for the relationships between health care professionals and patients to flourish.

CONCLUSION

For the reasons stated above, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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APPENDICES

APPENDIX A

AMICI CURIAE

The **American Medical Association (AMA)** is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and to improve the public health. The 290,000 members of the AMA practice in all states and in all fields of medical specialization. Among other efforts, the AMA is working with the Robert Wood Johnson Foundation in the development of an education program on advance care planning and palliative medicine designed to reach every physician and to improve the quality of patient care for individuals at the end of life.

The **American Nurses Association (ANA)** is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. It was founded in 1897 to promote the professional and educational advancement of nurses and to establish and maintain a code of ethics for the nursing profession. The ANA has 180,000 members and represents registered nurses in the United States and its territories through its 53 constituent member organizations. The ANA establishes professional standards for nursing practice, nursing education, nursing services and a code of ethical conduct for nurses, and the Association is dedicated to meeting the needs of nurses as well as the needs of patients and families.

The **American Association of Critical-Care Nurses (AACN)** is the world's largest specialty nursing organization with more than 76,000 members. Founded in 1969, the Association now has more than 270 chapters worldwide and is working toward a healthcare system driven by patient's needs where critical care professionals make their optimal contribution.

The **Hospice Nurses Association (HNA)** was founded in 1986 and is a non-profit professional association. The

HNA is an international professional association with a mission of promoting excellence in hospice nursing. The HNA is the nation's largest hospice nursing association and it is governed by an all nurse board of directors.

The **Oncology Nurses Society (ONS),** incorporated in 1975, is a national organization of more than 25,000 registered nurses specializing in cancer and dedicated to excellence in patient care, teaching, research and education in the field of oncology. The ONS has 185 local chapters that provide community networks for education and peer support. Oncology nurses are at the forefront of promoting quality of life as an essential component of cancer care.

The **American Osteopathic Association (AOA),** celebrating its centennial in 1997, represents the nation's 40,000 osteopathic (D.O.s). The AOA is organized to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality and cost-effective health care in a distinct, unified profession.

The **American Psychiatric Association (APA),** with approximately 42,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA follows the ethics standards of the American Medical Association. Physician-assisted suicide inevitably presents issues concerning the assessment of patient competence, the determination of voluntariness, and the diagnosis and treatment of depression or other mental illness afflicting patients who may request assistance for suicide. As doctors who would be called upon to play a critical role in such matters, the APA's members have a strong interest in this case.

The **American Academy of Hospice and Palliative Medicine (AAHPM),** originally organized as the Academy of Hospice Physicians in 1988, was established to bring together physicians interested and/or involved in the

hospice/palliative care approach to patient care and committed to improvement of care for the dying. The AAHPM is the only such organization in the United States that offers support to physicians dedicated to the advancement of hospice/palliative medicine, its practice, research and education. Its 1,500 member physicians represent nearly all medical specialties.

The **American Academy of Pain Management** was incorporated in 1988 as a voluntary, not-for-profit organization for the purpose of credentialing multidisciplinary pain practitioners, and to further the practice of pain management through the development of standards, education, and advocacy in the field of pain management. The Academy's Board of Advisors are prominent individuals in their respective disciplines and all are interested in furthering our knowledge and management of pain complaints. The intent of the Academy is to be inclusionary, not restrictive to any specialty, and the goal of the Academy is to bring together the many professionals who work with patients in pain and to assist in the creation of quality services for those individuals.

The **American Academy of Pain Medicine** is a medical specialty society of 900 physicians who specialize in the prevention, evaluation, diagnosis, treatment and rehabilitation of painful disorders. The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing pain relieving procedures, counseling of patients and families, direction of a multidisciplinary team, coordination of care with other health care providers and consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from a painful disorder.

The **American Academy of Orthopaedic Surgeons** is a not-for-profit organization that represents over 17,000 mem-

bers. The Academy provides educational programs for orthopaedic surgeons, allied health professionals, and the public. The Academy is an advocate for improved patient care.

The **American Academy of Physical Medicine and Rehabilitation** is a national medical specialty society representing more than 5,000 physicians who specialize in physical medicine and rehabilitation (physiatry), the branch of medicine emphasizing the prevention, diagnosis and treatment of disorders that may produce temporary or permanent impairment. Physiatry provides integrated care in the treatment of all neurologic and musculoskeletal disabilities from traumatic brain injury to lower back pain. The specialty focuses on the restoration of function to people with problems ranging from simple physical mobility issues to those with complex cognitive involvement.

The **Society of Critical Care Medicine (SCCM)** is the premier professional international organization devoted exclusively to the advancement of multidisciplinary critical care through excellence in patient care, education, research and advocacy. The nearly 9,000 members of SCCM—the intensivists, nurses and allied health professionals involved in the care of the critically ill and injured—blend their knowledge, skill, and expertise into a coordinated effort to achieve the best possible outcome for the patient.

The **American Academy of Neurology** is a non-profit organization of approximately 14,000 neurologists who practice throughout the United States and beyond. The Academy strives to serve the broad educational needs of its members; to encourage the highest standards of clinical care, education, and research in the field of neurology; and to advance the specialty of neurology and the well-being of those served by it. The Academy has taken a leadership role in developing substantive and procedural

guidelines for patient care and decision-making in such circumstances as persistent vegetative state, advanced dementia, profound and irreversible paralysis ("locked-in syndrome"), and anencephaly.

The **American Neurological Association** was founded in 1875 and today represents over 1,100 academic neurologists.

The **American Society of Anesthesiologists** was founded in 1905 in New York and currently has more than 34,000 members. It is a scientific and educational association of anesthesiologists that was organized to advance the practice of anesthesiology and to improve the quality of care of the anesthetized patient. It is the largest organization of anesthesiologists in the world.

The **American Society of Clinical Pathologists (ASCP)** is a non-profit medical specialty society organized for educational and scientific purposes. The 75,000 members of the ASCP include board certified pathologists, other physicians, clinical scientists, and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers more than 150,000 laboratory professionals annually.

The **College of American Pathologists (CAP)** is a medical society serving more than 15,000 physician members and the laboratory community throughout the world. Incorporated in 1947, the College is a not-for-profit organization. CAP is the world's largest association composed exclusively of pathologists and is widely considered to be the leader in laboratory quality assurance. The CAP is an advocate for high quality and cost-effective patient care. The mission of the College is to represent the interests of patients, the public and pathologists by fostering excellence in the practice of pathology worldwide.

The **American Society of Abdominal Surgeons (ASAS),** founded in 1959, is a private, voluntary, non-profit organization of physicians. Its mission is to develop a strong continuing surgical education program for the unique specialty of abdominal surgery. The 4,000 members of the ASAS practice in all states, Canada, and Mexico.

The **American Association of Clinical Endocrinologists (AACE)** is an international medical association devoted to the field of clinical endocrinology. Its more than 2,500 members are physicians with special education, training and interest in the practice of endocrinology. AACE members are clinicians and educators in areas such as diabetes, thyroid illnesses, lipid profiles, reproductive disorders, obesity, and nutrition.

The **California Medical Association (CMA)** is a non-profit, incorporated professional association of approximately 33,000 physicians practicing in the State of California. The CMA is the largest state medical association in the country, and the membership includes most California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are " . . . to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

The **Medical Society of the State of New York** was organized in 1807 and is incorporated and operated under the state's Not-for-Profit Corporation Law. The Society has approximately 27,000 member physicians, representing physicians in all specialties. The purposes of the Medical Society include: "To enhance the delivery of medical care of high quality to all people in the most economical manner, and to act to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public."

The **Medical Association of the State of Alabama** is a non-profit professional association of licensed physicians representing 5,600 members in the State. The Association was founded in 1873 and it is the premiere medical professional association in the State of Alabama.

The **Arkansas Medical Society** organized in 1875, is a non-profit, professional organization representing 3,857 licensed physicians in the State of Arkansas.

The **Medical Association of Georgia,** formed in 1849, is a non-profit professional association of approximately 7,500 licensed physicians who provide patient care in all aspects of medical practice in the State of Georgia.

The **Illinois State Medical Society** is a non-profit professional association of licensed physicians, residents and medical students, founded in 1840, and representing more than 18,000 members in the State of Illinois.

The **Indiana State Medical Association** is a non-profit, professional association of licensed physicians founded in 1849, and representing 7,200 physicians in all areas of medical practice in the State.

The **Iowa Medical Society** is a non-profit, professional association of licensed physicians founded in 1860, and representing 4,000 physicians in all areas of medical practice in the State.

The **Louisiana State Medical Society,** founded in 1878 and representing 6,340 physicians and medical students in Louisiana, is a non-profit, tax-exempt professional association. The Louisiana State Medical Society provides leadership for the advancement of the health of the people of Louisiana and is the premier advocate in Louisiana for patients and physicians.

The **Massachusetts Medical Society** is the oldest, continuous non-profit, professional medical association in the United States. Founded in 1781, it represents approximately 16,000 members in the State.

The **Mississippi State Medical Association** is a private, voluntary, non-profit organization, which was founded in 1856 to promote the extension of medical knowledge, the advancement of medical science, the elevation of the standard of medical education, the enactment of just medical laws and the improvement of public health. The Association's membership consists of approximately 3,000 physicians licensed to practice medicine in the State of Mississippi.

The **Missouri State Medical Association** is a non-profit professional association of physicians licensed to practice medicine in Missouri and students training in the state's accredited medical schools. The Missouri State Medical Association was founded in 1850 and currently represents and serves approximately 6,300 members.

The **Montana Medical Association** is a non-profit organization comprised of physician members. The Association was chartered in 1878 and represents 960 licensed physicians in the State of Montana.

The **Nebraska Medical Association** is a non-profit, professional association of licensed physicians founded in 1868, and representing 1,952 members in the State.

The **Medical Society of New Jersey** is the nation's first medical society, founded in 1766. With more than 9,500 physician members, the Society is the State's leading voice in the health care field. The Society's mission is to promote the quality of New Jersey health care and health services for all of the citizens of the state through leadership and assistance to its physician members.

The **New Mexico Medical Society** is a non-profit, professional association of licensed physicians founded over 100 years ago, and representing 2,800 members in the State.

The **North Carolina Medical Society** is a non-profit, professional association which represents physicians in North Carolina and has approximately 9,000 members. The Society was incorporated by an Act of the North Carolina General Assembly in 1858.

The **Ohio State Medical Association (OSMA)** is a non-profit professional association of approximately 16,000 physicians, medical residents and medical students. OSMA's membership includes physicians in all specialties engaged in the private practice of medicine in the State of Ohio. OSMA's purposes are to: improve public health through education, encourage interchange of ideas among members and maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The **Tennessee Medical Association** is a non-profit corporation formed in 1830 and is composed of approximately 6,800 medical doctors licensed in Tennessee, including medical students and medical residents seeking licensure.

The **Texas Medical Association** is a private, voluntary, non-profit organization of physicians founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. It has aproximately 34,000 members representing 84% of all licensed physicians practicing in Texas.

The **Vermont Medical Society** is a non-profit professional association of licensed physicians. The Society was founded in 1784 and represents over 1,100 members.

The **Medical Society of the State of Virginia** is a not-for-profit professional association of over 6,500 member physicians representing every medical specialty and proportionally represented throughout Virginia. The mission of the Society is to: preserve, defend and enhance the doctor-patient relationship; promote better health and health care for all Virginians; support the discovery and dissemination of new knowledge of human death and disease; and in all these things to articulate the position of organized medicine, consistent with the highest standards of the medical profession.

The **West Virginia Medical Association,** founded in 1867, is a non-profit professional Association of licensed physicians and represents 2,100 members in the State.

The **Society of Medical Consultants to the Armed Forces** was formed in 1946. The goals of the society include: assisting in the development and maintenance of the highest standards of medical practice in the Armed Forces; and providing advice and assistance to the Surgeons' General on problems of professional importance in the Armed Forces.

The **American Institute of Life-Threatening Illness and Loss,** a division of the Foundation of Thanatology which was incorporated in 1967 in the State of New York, is dedicated to promoting vastly improved psychosocial and medical care for patients critically ill or dying from (among multiple diseases) cancer, heart disease, AIDS, stroke, end stage renal disease, and emphysema. A major emphasis of the Foundation is on medical education and quality of life studies. Over the past 25 years, the Foundation has held over 115 national symposia and published over 115 related books.

The **National Hispanic Council on Aging** is a private organization that works to promote the well-being of older Hispanics. It was founded in 1980, and there are approximately 5,000 members throughout the United States, Puerto Rico, and Mexico.

APPENDIX B

OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AMERICAN MEDICAL ASSOCIATION

Opinion 2.211—Physician Assisted Suicide. Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993; Updated June 1996. (I, IV)

Opinion 2.20—Withholding or Withdrawing Life-Sustaining Medical Treatment. The social commitment of the

physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decisionmaker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any);

the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decisionmaking process: (a) there is no available family member willing to be the patient's surrogate decisionmaker, (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (c) a health provider believes that the family's decision is clearly not what the patient would have decided if competent, and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. Issued March 1981 (Opinion 2.11: Terminal Illness) and December 1984 (Opinion 2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences). Updated June 1994 based on the reports "Decisions Near the End of Life" and "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patient," both issued June 1991; and Updated June 1996. (I, III, IV, V)

Opinion 2.22—Do-Not-Resuscitate Orders. Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that cardiopulmonary resuscitation (CPR) would be inappropriate or not in accord with the desires or best interests of the patient.

Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR.

If a patient is incapable of rendering a decision regarding the use of CPR, a decision may be made by a surrogate decisionmaker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests.

If, in the judgment of the attending physician, it would be inappropriate to pursue CPR, the attending physician may enter a do-not-resuscitate (DNR) order into the patient's record. Resuscitative efforts should be considered inappropriate by the attending physician only if they cannot be expected either to restore cardiac or respiratory function to the patient or to meet established ethical criteria, as defined in the Principles of Medical Ethics and Opinions 2.03 and 2.095. When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion (e.g., consulting a bioethics committee) or arranging for transfer of care to another physician.

DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient. Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," issued December 1990. Updated June 1994. (I, IV)

Opinion 2.035—Futile Care. Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in opinions 2.03 and 2.095, not on the concept of "futility," which cannot be meaningfully defined. Issued June 1994. (I, IV)

Opinion 2.21—Euthanasia. Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the report "Decisions Near the End of Life," issued June 1991; Updated June 1996. (I, IV)

Opinion 2.06—Capital Punishment. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into

one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical diagnoses as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying to the medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned

person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued. However, if the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. Provision of medical testimony in the reevaluation of the prisoner's legal competence to be executed should be provided by an independent physician examiner. A physician cannot be compelled to provide medical testimony as it relates to legal competence for execution if it is contrary to the physician's personal beliefs.

Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," issued December 1992 (JAMA. 1993; 270: 365-368), and updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," issued in June 1995. (I)

APPENDIX C

AMERICAN NURSES ASSOCIATION

CODE FOR NURSES WITH INTERPRETIVE STATEMENTS

1.1 Respect for Human Dignity

* * * Clients have the moral right to determine what will be done with their own person; to be given accurate information, and all the information necessary for making informed judgments; to be assisted with weighing the benefits and burdens of options in their treatment; to accept, refuse, or terminate treatment without coercion; and to be given necessary emotional support.

* * * *

POSITION STATEMENT ON ASSISTED SUICIDE

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the *Code for Nurses with Interpretive Statements (Code for Nurses)* and the ethical traditions of the profession. Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments.

* * * *

POSITION STATEMENT ON PROMOTION OF COMFORT AND RELIEF OF PAIN IN DYING PATIENTS

Summary: The American Nurses Association (ANA) believes that the promotion of comfort and aggressive efforts to relieve pain and other symptoms in dying patients are

obligations of the nurse. Nurses should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying patient. The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified.

* * * *

POSITION STATEMENT ON ACTIVE EUTHANASIA

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in active euthanasia because such an act is in direct violation of the *Code for Nurses with Interpretive Statements (Code for Nurses)*, the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide timely, humane, comprehensive and compassionate end-of-life care.

* * * *

No. 96-110

Supreme Court, U.S.
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON and CHRISTINE O. GREGOIRE,
Attorney General of the State of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D. PH.D.,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

BRIEF AMICUS CURIAE OF THE NATIONAL RIGHT TO LIFE COMMITTEE, INC. IN SUPPORT OF PETITIONERS

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November 12, 1996

QUESTIONS DEALT WITH HEREIN

The issue in this case is whether there is a constitutional right to commit suicide and, if so, whether it includes a right to assistance.

The sub-issues dealt with herein are:

1. What principles established by this Court govern the formulation of proposed fundamental rights to be measured for fundamentality against the history and tradition of our Nation?

2. Under these principles, what is the proper formulation of the proposed fundamental right in this case?

3. Measuring the properly-formulated, proposed fundamental right against the history and tradition of our Nation, does a fundamental right exist which governs the decision in this case?

4. Does this Court's abortion or refusal of treatment jurisprudence require it to proclaim a constitutional right to assisted suicide?

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INTEREST OF AMICI CURIAE[1]

The National Right to Life Committee, Inc. ("NRLC) is a nonprofit organization whose purpose is to promote respect for the worth and dignity of all human life, including the life of persons until the time of natural death. NRLC is comprised of a Board of Directors representing 51 state affiliate organizations and about 3,000 local chapters made up of individuals from every race, denomination, ethnic background, and political belief. It engages in various political, legislative, legal, and educational activities to protect and promote the concept of the sanctity of innocent human life. The members of NRLC have been strong proponents of laws protecting innocent human life from the time of conception until the time of natural death. The members of NRLC have actively opposed the various recent initiatives to overturn statutes barring assisted suicide. NRLC seeks to advance its interests by addressing the legal issues herein.

SUMMARY OF THE ARGUMENT

Prior to measuring a proposed fundamental right against the history and tradition of our Nation — to determine whether it has been considered a fundamental liberty — the proposed right must be properly formulated. Failure to properly formulate the proposed right risks constitutionally illegitimate decisions. To avoid this problem, this Court has employed certain principles in formulating proposed fundamental rights. These are formulated herein into a derived rule.

As a general rule, the precedents of this Court require that a proposed right be expressed in a concrete, fact-sensitive manner. This general rule is comprised of a three-prong consideration. First, the formulation of a proposed fundamental right should focus on the activity proposed to be protected by taking into account all relevant facts. Second, the formulation of a proposed fundamental right should not be overbroad so as to encompass other activities which are logically distinct and involve separate considerations.

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[1]Consents from the parties to filing this brief have been filed with the Clerk. Amicus curiae expresses its appreciation to Kristian M. Dahl, Esq. for assistance in writing this brief.

Third, the formulation of a proposed fundamental right should reasonably accommodate all the interests at stake in the case.

Under these principles, established by the precedents of this Court, the formulation of the proposed fundamental right in this case must be whether there is a fundamental right to commit suicide and, if so, whether the right includes assistance in committing suicide. Other formulations proposed by plaintiffs/respondents are so overbroad as to encompass numerous other activities never recognized as lawful or constitutionally protected.

Applying the proper test to a properly framed issue reveals that there is no recognized constitutional liberty interest in committing assisted suicide. However, even if there were, there are compelling interests which override the interest, preventing the recognition of a fundamental right to have assistance in committing suicide.

I. AN ISSUE TESTED AS A FUNDAMENTAL RIGHT MUST BE FRAMED IN A CONCRETE, FACT-SENSITIVE MANNER BEFORE BEING MEASURED OBJECTIVELY AGAINST THE HISTORY AND TRADITION OF OUR NATION.

The first step in determining whether there is a constitutional right to assisted suicide is to frame the proposed right in a concrete, fact-sensitive manner. The proper question herein is a straightforward one: "Is there a constitutional right for terminally-ill, competent adults to commit suicide and, if so, whether it includes a right to assistance?" *See People v. Kevorkian*, 447 Mich. 436, 476 n.47, 527 N.W.2d 714, 730 n.47 (1994), *cert. denied sub nom. Kevorkian v. Michigan*, 115 S. Ct. 1795 (1995). This topic is treated in subsection I.A., *infra*.

Once a concrete formulation of a right proposed for constitutional protection is framed, a neutral, constitutionally legitimate analysis for evaluating proposed fundamental rights must be used. The best-reasoned constitutional opinions of this Court have relied on the historical, objective test for fundamentality, i.e., whether the proposed right is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934). This subject is discussed in subsection I.B., *infra*.

A. *In Framing an Issue to be Tested as a Fundamental Right, the Issue Must Be Framed in a Concrete and Fact-Sensitive Manner, i.e., "Is There a Fundamental Right to Commit Suicide and, if so, Does It Include a Right to Assistance?"*

In proposing an asserted fundamental right, the issue tested must be framed in a concrete, fact-sensitive manner. Otherwise, the framing of the issue can determine an outcome not reachable by an objective, legitimate analysis. As this Court has stated recently:

> "Substantive due process" analysis must begin with a careful description of the asserted right, for "[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field." *Collins [v. City of Harker Heights]*, 503 U.S. [115], [125 (1992)] . . . ; *see Bowers v. Hardwick*, . . . 478 U.S. [186,] 195-95 (1986)] . . . .

Reno v. Flores, 113 S. Ct. 1439, 1447 (1993).

The Ninth Circuit did not frame the issue in this case as whether there is a right to commit suicide and, if so, whether the right includes a right to assistance, which would be the proper formulation. Rather, the Ninth Circuit chose this formulation: "Today we are required to decide whether a person who is terminally ill has a constitutionally-protected liberty interest in hastening what might otherwise be a protracted,[2] undignified, and

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[2]Although this case purportedly involves an as-applied challenge, the terminally-ill plaintiffs/respondents all died while the case was in the district court or on appeal. Thus, this case is more correctly viewed as a facial challenge which must fail because there are applications of Washington's assisted suicide prohibition which are unquestionably constitutional. *United States v. Salerno*, 481 U.S. 739 (1987). Respon-

(continued...)

extremely painful death," *Compassion in Dying v. State of Washington*, 79 F.3d 790, 793 (9th Cir., 1996), including "the prescribing of medication by a physician for the purpose of enabling a patient to end his life." *Id.* at 802. The Ninth Circuit combined a multi-conditioned "right to die" with specific conduct, resulting in the de facto creation of a right to assisted suicide. Rather than simply and correctly framing the asserted right as a right to assisted suicide, the Ninth Circuit chose broader, more amorphous language about hastening death to permit it to reach its chosen outcome.

In an attempt to justify its finding of a right to assisted suicide, the Ninth Circuit further broadened its formulation of the asserted fundamental right, citing the *Casey* decision's supposed privacy right in matters "involving the most intimate and personal choices." *Id.* at 801 (*citing Planned Parenthood of S.E. Pennsylvania v. Casey*, 505 U.S. 833, 851 (1992)). The proper question is not whether individuals have "the right to define one's own concept of existence," or the right to make "intimate and personal choices . . . central to personal dignity and autonomy," as the joint opinion in *Casey* and the Ninth Circuit have characterized the privacy right. *Casey*, 505 U.S. at 851. Neither is the issue whether there is a "right to die. *Compassion in Dying*, 79 F.3d at 801."[3]

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[2](...continued)
dents, with assistance from the Ninth Circuit, are attempting to establish a broadly available regime of assisted suicide and active euthanasia (even for incompetent persons via substituted judgment) by (1) bypassing the *Salerno* rule by attempting to position this case as an as-applied challenge and then (2) (if a right is declared for the "as applied" group) using that right as an equal-protection lever to expand the right to both a broader group and to an active euthanasia right. The principles of *Salerno* should govern this transparent effort, which should be rejected. In any event, the fact-based formulation used by the Ninth Circuit in the passage quoted is inappropriate given the absence of terminally ill persons as parties in this case.

[3]While the Ninth Circuit *en banc* panel often labels the right tested (continued...)

These broad, grand-sounding, generalized efforts to describe this Court's privacy jurisprudence could be interpreted to constitutionalize all sorts of behavior, legal and illegal. It is noteworthy that these sweeping efforts to summarize the right to privacy in *Casey* were given in that case only after a concrete list of actual, concrete applications of the privacy doctrine. The list included, the right to make "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education." *Casey*, 505 U.S. at 851. The Court went on to give even more specific examples of rights recognized in these areas. *Id.* It is these concrete examples which demonstrate the true content of the privacy right recognized by this Court, not the abstract formulations which could sweep in both constitutionally protected and unprotected activities, and which leave a court free to add new constitutionally protected activities at will.

Deciding how to properly frame a proposed constitutional right to be tested to see if it rises to the level of a fundamental right has been a long-standing problem. A right not properly framed may sweep too broadly. For example, an attempt to combine the right to contraception and the right to abortion into a right to control the makeup of one's family might seem at face value to make sense. However, such an overarching right would logically encompass, inter alia, the right to commit infanticide, a time-honored method of controlling family size in many cultures, but one traditionally rejected in our own. Similarly, a right to control the makeup of one's family would logically encompass the right to engage in

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[3](...continued)
as the "right to die," *Compassion in Dying*, 79 F.3d at 801, 802, 803, it attaches so many conditions on this term as to make it an unworkable statement of the right being tested. Among the conditions are the presence of adequate safeguards, *id.* at 821, a limitation to "patients," *id.* at 797, 820, or to "terminally ill," *id.*, "conscious adults," *id.* at 817, who must be "competent adults," *id.*, and not suffering from "treatable mental disorders," *id.* at 820. At one point the panel speaks of those with "unmanageable pain and suffering," *id.* at 824, although it never limits the right it proclaims in this supposed facial challenge to such persons.

polygamy. Of course, neither infanticide nor polygamy have been recognized as fundamental rights. What is clear from this illustration is that this Court has found contraception and abortion to be fundamental rights, but there is no right to control the makeup of one's family. The right is framed too broadly.

Neither has there ever been recognized a right to "define one's own concept of existence." Such efforts to create overarching rights are an attempt to synthesize the privacy decisions of this Court. However, using them as the measuring rod for testing newly proposed rights for fundamentality is plain error.

Because of the problems posed by an overbroad formulation of a proposed right, this Court has established certain principles, which may be derived from its opinions, for formulating proposed rights to be tested for fundamentality. The Michigan Supreme Court gave thoughtful consideration to the framing of the proposed right in *People v. Kevorkian*, 447 Mich. 436, 476 n.47, 527 N.W.2d 714, 730 n.47 (1994), *cert. denied sub nom. Kevorkian v. Michigan*, 115 S. Ct. 1795 (1995), a case rejecting a federal constitutional right to assisted suicide:

> [I]t is important to the analysis of substantive due process that the asserted right be framed in a precise and neutral manner. This is critical in cases involving end-of-life questions, which are particularly susceptible to emotion-laden terminology and flawed syllogisms. The approach of the United States Supreme Court in assessing whether a proposed right is "fundamental" has been to narrow the threshold inquiry by applying three principles: (1) the focus should be on the specific activity that proponents argue is protected by the constitution, taking into account all relevant facts, (2) the formulation should not be so broad as to encompass activities that are logically distinct and involve separate considerations, and (3) the formulation should reasonably accommodate all of the interests at stake. Bopp & Coleson, *Webster and the Future of Substantive Due Process*, 28 Duq. L. R. 271, 281-291 (1990). *See Webster v. Reproductive Health Services*, 492 U.S. 490 . . . (1989). The question presented in this case thus is not whether a person has a

> constitutional right of self-determination, or a right to define personal existence, or a right to make intimate and personal choices, or a right not to suffer. Rather, the question that we must decide is whether the constitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance.

As stated by the Michigan Supreme Court, this Court's approach has been to frame rights framed in a concrete, fact-sensitive manner. This requires application of three principles. Bopp & Coleson, *Webster and the Future of Substantive Due Process*, 28 Duquesne L. R. at 284-87 (hereinafter "*Substantive Due Process*").

"First, the formulation of a proposed fundamental right should focus on the activity proposed to be protected by taking into account all the relevant facts." *Id.* at 284. This requires focus on the actual activity proposed for constitutional protection, not broad, abstract descriptions of historically-recognized rights. As noted above, the broad language of *Casey*, which the Ninth Circuit followed, could allow vast numbers of asserted rights to be swept within the constitutional fortress. The actual level of specificity must take into account all relevant facts relating to the activity proposed for constitutional protection. Focusing on the actual, concrete activity proposed and all relevant facts relating to it will enable the framing of an issue which is neither too broad nor too narrow. *Id.* at 284-85.

Numerous examples abound in Supreme Court jurisprudence. Consider the example of marriage. This Court has recognized a constitutional right for a man and woman to marry. *Loving v. Virginia*, 388 U.S. 1 (1967). The issue was framed in a concrete manner focusing on the actual activity proposed for protection, i.e., marriage, as opposed to some broad, amorphous right, e.g., the right to control the makeup of one's family. However, because marriage is a covenant between a man and a woman to join together in a societally-sanctioned relationship, the fact that the individuals are of a different race is irrelevant to the formulation of the right proposed. *Id.* (miscegenation law struck down on equal

protection and substantive due process grounds). As a result, the proper balance is struck between concrete focus on the activity and omitting irrelevant facts by framing the issue in *Loving* as whether there is a constitutionally protected right for a man and a woman to marry. Similarly, the fact that one party to a proposed marriage is a prisoner is irrelevant to the formulation of the right to marry, *Turner v. Safley*, 482 U.S. 78 (1987), but marriage to a person of the same sex is a highly relevant fact, for it would radically alter the definition of marriage. *See Baker v. Nelson*, 291 Minn. 310, 315, 191 N.W.2d 185, 187 (1971) ("[I]n common sense and in a constitutional sense, there is a clear distinction between a marital restriction based merely upon race and one based upon the fundamental difference in sex."), *appeal dismissed*, 409 U.S. 810 (1972).

"Second, the formulation of a proposed fundamental right should not be overbroad so as to encompass other activities which are logically distinct and involve separate considerations." *Substantive Due Process* at 286. In considering the constitutionality of a law barring polygamous relationships, it would be overbroad to frame the issue in terms of a right to marriage, which is constitutionally protected. Given the context of the case in which a right to marriage was pronounced, it is evident that the right is to a monogamous relationship. *Loving v. Virginia*, 388 U.S. 1 (1967). While polygamy may be ranked as fundamental in the history and tradition of some cultures throughout history, it has not been so ranked in our Republic. *Reynolds v. United States*, 98 U.S. 145 (1878) (upholding anti-polygamy laws against constitutional attack).

"Third, the formulation of a proposed fundamental right should reasonably accommodate all the interests at stake in a case." *Substantive Due Process* at 286. While this prong may seem somewhat overlapping with the prior parts of the test, it is designed to guarantee that in eliminating allegedly irrelevant facts from the formulation no interests of others are pruned away. For example, in formulating a proposed right to discharge a firearm, it is logically relevant whether the firearm is being discharged into another person.

Certain decisions of this Court illustrate these principles well. In the case of *Michael H. v. Gerald D.*, 491 U.S. 110 (1989), this Court considered the case of a man who allegedly fathered a child by an adulterous relationship with the wife of another man. The plurality formulated the proposed right as "the power of the natural father to assert parental rights over a child born into a woman's existing marriage with another man." *Id.* at 125. This formulation demonstrates the above tri-part rule. First, the formulation is concrete and fact-sensitive, including all relevant facts. Second, the formulation is not overbroad, so as to encompass other activities which are logically distinct and involve other considerations. Third, the formulation does not exclude the interests of all involved in the situation. The Court correctly did not merely ask whether natural fathers have constitutional rights involving their children.

Similarly, the case of *Bowers v. Hardwick*, 478 U.S. 186 (1986), demonstrates the proper framing of a proposed constitutional right. *Bowers* involved an appeal from the criminal prosecution of two male homosexuals arrested by a police officer *in flagrante delicto* for violation of a state sodomy law. The Court framed the issue in a concrete fact-specific manner, including only relevant facts, and accounting for all interests, deciding whether there was a right to engage in "consensual homosexual sodomy." *Id.* at 188 n.2. This formulation dealt with the statute as it was applied in the action before the Court, excluding the irrelevant detail of whether the activity involved oral or anal genital contact. The Court's formulation also excluded nonconsensual and heterosexual sodomy, which were beyond the facts of this case, and any discussion of third parties, which were not involved in any way. Framing the issue so as to encompass heterosexual sodomy would have also involved logically distinct considerations, such as whether, if a couple were married, the principles undergirding *Griswold v. Connecticut*, 381 U.S. 479 (1965) (striking down any restriction on contraceptives for married couples), would preclude regulation of heterosexual sodomy.

By contrast, the *Bowers* dissent chose broad, abstract formulations of the proposed constitutional right which would encompass

homosexual activity. For example, Justice Blackmun spoke of "the right to be let alone," *Bowers*, 478 U.S. at 199 (Blackmun, J., dissenting) (quotation marks and citation omitted), the right to make "certain *decisions*" and do activities in "certain *places*," *id.* at 204 (emphasis in original), to do things which "form so central a part of an individual's life," *id.*, "the ability independently to define one's own identity," *id.* at 205 (quotation marks and citations omitted), "the freedom an individual has to choose the form and nature of these intensely personal bonds," *id.* (emphasis in original), "the fundamental interest all individuals have in controlling the nature of their intimate associations with others," *id.* at 206, "the right of an individual to conduct intimate relationships in the intimacy of his or her own home," *id.* at 208, and "the right to differ as to things that touch the heat of the existing order." *Id.* at 211. In addition, three dissenters joined in formulating the proposed right as "the individual's right to make certain unusually important decisions that will affect his own, or his family's destiny." *Id.* at 217 (Stevens, J., dissenting).

By framing the issue herein as "the right to die," the Ninth Circuit creates a right so broad that it would encompass everything from refusal of treatment to euthanasia, with assistance by health care workers, families, and even friends, not just physicians. *Compassion in Dying*, 79 F.3d at 819, 825-28, 857. The purported liberty interest is stated in terms of avoiding pain, yet this purportedly as-applied challenge is not brought (nor is relief granted) only for those in intractable pain, and the en banc panel also suggests a desire to avoid medical bills may allow the interest in question to prevail. *Id.* at 826. Additionally, the "right to die" of the Ninth Circuit would not be limited to mentally competent people, as duly appointed surrogates would be recognized equally to the patient himself. *Id.* Finally, the Ninth Circuit states that future "right to die" cases could expand to encompass other forms of life-ending medical assistance, such as the administration of drugs by a physician, i.e., active euthanasia. *Id.* at 831. The Ninth Circuit acknowledges that there is no clear demarcation between physician-assisted suicide and the administration of deadly drugs. *Id.*

The Ninth Circuit decided to label the tested right the "right to die." This was done to lump assisted suicide, widely prohibited and not historically recognized as a right, with more popular and well-recognized conduct involving end-of-life decisions, such as disconnecting a brain-dead, comatose patient from a respirator, or the right to refuse medical treatment recognized in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). Similarly, framing the asserted right to assisted suicide as a right to "hasten" one's death or to choose the timing and manner of one's death is an effort to find support for assisted suicide by lumping it with treatment refusal and withdrawal law.[4]

As may be seen from these examples, the only appropriate formulation of the proposed constitutional right herein is whether there is a fundamental right to assisted suicide. Any more generalized expression, such as the broad language cited from the *Casey* joint opinion or the "right to die" also favored by Respondents and the Ninth Circuit, is an effort to resolve the issue by framing the question in a manner permitting the chosen outcome, rather than by a neutral constitutional analysis.

B. *The Test for Constitutionality of a Statute Must Be Objective and Historically-Anchored.*

A necessary corollary to a neutral formulation of a right proposed for constitutional protection is a neutral method of testing whether the proposed right is a fundamental one. Without a

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[4]The Ninth Circuit appears to make an effort to frame the issue of this case in a fact-sensitive manner by stating it as follows: "Whether a person who is terminally ill has a constitutionally-protected [Fourteenth Amendment due process] liberty interest in determining the time and manner of one's own death." *Compassion in Dying* at 793. At numerous other parts in the Ninth Circuit decision, the question changes to "the right to die," *Compassion in Dying* at 802, "hastening one's death for an important reason," *id.* It is noteworthy that the requirement that a physician assist the suicide is not even essential to the analysis. Writing for the majority, Judge Reinhardt states that "[I]t is the end and not the means that defines the liberty interest." *Id.* at 801.

neutral, constitutionally legitimate analysis for evaluating proposed fundamental rights, the integrity of the judiciary is undercut and decisions are without authority. If "the only limits to . . . judicial intervention become the predilections of those who happen at the time to be Members of th[e Supreme] Court," *Moore v. East Cleveland*, 431 U.S. 494 (1977), then the very rule of law has been supplanted by the rule of men.

The decision of the People of the United States in establishing their governmental Constitution was to adopt a rule of law, not a rule by men by Platonic guardians in the judiciary or any other branch of the government. As a result, a court must demonstrate by carefully reasoned analysis that its opinion is firmly anchored in the Constitution to be legitimate. Justice White expressed the danger of unfettered discretion by the judiciary:

> The Judiciary, including this Court, is the most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or even the design of the Constitution. Realizing that the present construction of the Due Process Clause represents a major judicial gloss on its terms, as well as on the anticipation of the Framers . . . , the Court should be extremely reluctant to breathe still further substantive content into the Due Process Clause . . . .

Id. at 544 (White, J., dissenting) (quoted in *Michael H.*, 491 U.S. at 122 (plurality opinion); *cf. Bowers*, 478 U.S. at 194.

Because of the danger of illegitimacy, the best-reasoned Constitutional opinions of the Supreme Court have relied on an historical, objective test for fundamentality, i.e., whether the proposed right is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934). This historical formulation of the test for fundamentality was central to the constitutional analysis in the *Bowers* case. 478 U.S. at 193-94 (plurality opinion). The *Bowers* opinion also made reference to another test, from *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), i.e., whether the proposed fundamental right is "'implicit in the concept of ordered liberty'

s[o] that 'neither liberty nor justice would exist if [they] were sacrificed.'" *Bowers*, 478 U.S. at 191-92 (quoting *Palko*, 302 U.S. at 325-26). Similarly, in *Michael H.*, Justice Scalia noted the dangers of illegitimate decisions, *Michael H.*, 491 U.S. at 122, and the importance of establishing legitimacy with an historical, objective test for fundamentality. In sum, the two complimentary tests for fundamentality are whether the proposed right is (1) implicit in the concept of ordered liberty and/or (2) so rooted in the traditions and conscience of our people as to be ranked as fundamental.

Plaintiffs/Respondents will dispute whether these tests govern, arguing that the Supreme Court has rejected such tests by rejecting completely any use of a formulary approach to determining what rights are protected under the Due Process Clause's liberty guarantee. *Casey*, 505 U.S. at 849-850. Although space does not allow an exhaustive analysis of the Supreme Court's recent debates with regard to testing proposed constitutional rights for fundamentality, a brief discussion will put the reference about no "formula" from *Casey* in context and show that it does not mean that this Court has thrown traditional substantive due process analysis out the window.

From the earliest ventures of this Court into substantive due process, the Court has had to deal with what tests would govern whether a proposed right would be found to be a fundamental constitutional right. The Court has consistently held that the mere whim of five Justices would not be enough to establish a constitutional right. Some effort had to be made to keep judges from "roaming at large in the constitutional field." *Griswold v. Connecticut*, 381 U.S. 479, 502 (Harlan, J., concurring).

The tests were established early in the development of substantive due process analysis. They were, as noted above: (1) whether the proposed right is "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder*, 291 U.S. at 105, or (2) whether proposed fundamental rights are "implicit in the concept of ordered liberty so that neither liberty

nor justice would exist if [they] were sacrificed." *Palko*, 302 U.S. at 325-26.

There have been two efforts to refine the test for fundamental rights. One would have required that no fundamental rights could be found in the Due Process Clause unless they were enumerated in the Constitution. This incorporation doctrine was what Justice Harlan objected to in *Griswold*, 381 U.S. at 500 (Harlan, J., concurring) and in *Poe v. Ullman*, 367 U.S. 497, 541 (1961) (Harlan, J., dissenting), when he said that "process has not been reduced to any formula." *Id.* at 542. The Supreme Court has rejected the incorporation doctrine by expanding the list of fundamental rights to include rights not expressly listed in the Constitution.

A second effort to refine the test for fundamental rights was made by Justice Scalia, with support from Chief Justice Rehnquist, who argued that in formulating a proposed right to be tested for fundamentality the Court must use the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified. *Michael H. v. Gerald D.*, 491 U.S. 110, 128 n.6 (1989) (opinion of Scalia, J.). While Justices O'Connor and Kennedy joined the rest of Scalia's opinion, they refused to join this footnote six formulation regarding the specific level of generality for formulating a proposed fundamental right, declining to foreclose the unanticipated by the prior imposition of a single mode of historical analysis. *Id.* at 132.[5]

These, then, are the debates which spill into the *Casey* opinion, *Casey*, 505 U.S. at 849-850, and upon which Respondents rely for the notion that the Court rejects any type of formulary approach to determining what rights are protected under the Due Process

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[5]The discussion, *supra*, about the proper framing of an asserted right takes the debate over this footnote into account and applies even if the right is not framed at the most specific level for which there is an historical tradition. However, as noted in the text, concern over cases such as *Loving v. Virginia* may be simply resolved by properly framing the issue. *See supra* at 7.

Clause's "liberty" guarantee, such as whether the right was "deeply rooted in this Nation's history and tradition," or whether "liberty or justice would cease to exist if [it] were sacrificed." These tests have not changed and ought not to be changed.

Clearly Respondents misunderstand the debate on the Supreme Court. A careful reading of *Casey* will reveal that the majority of this Court rejects formulation of proposed rights at only the most specific level and rejects the notion that only those rights "that were protected against governmental interference by other rules of law when the Fourteenth Amendment was ratified" may be found to have substantive due process protection. *Casey*, 505 U.S. at 847-48. The Court reiterates the latter point: "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Id.* at 848. The *Casey* majority then proceeded to quote Justice Harlan's dissent in *Poe v. Ullman* for the proposition that "[d]ue process has not been reduced to any formula." *Id.* at 848-49; *Poe*, 367 U.S. at 542. Justice Harlan's analysis was adopted in *Griswold*, 381 U.S. 487.

What Respondents fail to notice is that in Justice Harlan's dissent in *Poe*, he endorsed the notion that the Court should look to history in determining whether proposed rights should be deemed fundamental, i.e., look to "the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke." *Poe*, 367 U.S. at 542. With regard to assisted suicide, the tradition of our people has been to prohibit it and there is no significant of departure from that tradition. Likewise, in *Griswold* Justice Harlan, while still rejecting the formula of the incorporation doctrine, *Griswold*, 381 U.S. at 500-01, at the same time endorsed the *Palko* test: "In my view, the proper constitutional inquiry in this case is whether this Connecticut statute infringes the Due Process Clause of the Fourteenth Amendment because the enactment violates basic values 'implicit in the concept of ordered liberty.'" *Id.* at 500 (citation omitted).

In other words, the Justice whom Plaintiffs/Respondents cite for a rejection of any "formulary" approach specifically embraced the tradition-of-our-people and implicit-in-ordered-liberty tests which Respondents would reject as being too formalistic. Nor is there any evidence that any of the Judges on the Supreme Court, in *Casey* or elsewhere, have abandoned these two historical tests. The debate lies elsewhere. These tests are well-established and must be applied in this case.

C. *The Analysis of* Planned Parenthood of S.E. Pennsylvania v. Casey *Is Inapplicable to Assisted Suicide.*

Respondents attempt to establish a constitutional right to assisted suicide by analogy to the right to abortion, relying on certain broadly-worded language of the *Casey* decision, 505 U.S. 833, and the right to refuse medical treatment, as expressed in *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990). The tenuous analogies to *Casey* and *Cruzan* were adopted by the Ninth Circuit as well. *Compassion In Dying*, 79 F.3d at 813-16. As shown below, the "analogy" approach is an inappropriate methodology, even if the analogies proposed were sufficiently parallel, which they are not. Moreover, *Casey* is inapposite as shown below, and *Cruzan*, while somewhat more conceptually related, actually leads to a different conclusion than the en banc Ninth Circuit panel reached.

Respondents attempt their analogy by using selective, general language from the *Casey* opinion involving "intimate and personal choices . . . central to personal dignity and autonomy" and "the right to define one's own concept of existence." *Compassion In Dying* at 813 (quoting *Casey*, 505 U.S. at 853). Such a broad, general framing of constitutional rights is inappropriate, as discussed in detail *supra*, because it gives courts absolute discretion to place new rights within the pale of constitutional protection. For the present, however, it is important to note how inapposite the abortion right is to a right to assisted suicide. Two key differences demonstrate the error of relying on Casey for a right to assisted suicide. *See also*, Spindelman, *Are the Similarities Between a Woman's Right to Choose and Abortion and the Alleged Right to*

Assisted Suicide Really Compelling?, 20 U. Mich. J. of L. Reform 775 (1996); and Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide — And Why These Reasons Are Not Convincing*, 12 Issues in L. & Med. 113 (1996).

1. *Casey*, an Abortion Case, Dealt with "Potential Life," Not Born Persons.

From the time of *Roe v. Wade*, 410 U.S. 113 (1973), a woman's interest in obtaining abortion has been balanced against what the Court described as the "potentiality of human life." *Id.* at 162. Casey likewise describes the life interest at stake in the abortion decision as "potential life." *Casey*, 505 U.S. at 871. With regard to life that is only asserted to be "potential," *Roe* acknowledged no compelling state interest until viability. At viability, however, a state's interest in protecting this "potential" life became a "compelling" interest, overriding a woman's right to choose abortion. *Roe*, 410 U.S. at 163.

In the context of dealing only with "potential" life, the *Casey* joint opinion asserted that the proper mode of balancing was the undue burden standard. *Casey*, 505 U.S. at 876. Of course, after viability the state's interest in protecting unborn life becomes compelling and abortion may be proscribed, *id.* at 869, even though unborn life remains "potential." *Id.* at 871, 876.

If a state's interest in protecting "potential" life may become compelling at some point, how much greater must be the state interest in protecting the human life of born persons. The interest in protecting this "actual" life would also be compelling and would be sufficiently powerful to allow the state to criminalize either the destruction of that life or assisting in the destruction of that life, just as it may bar the destruction of viable "potential" life.

The state's compelling interest in protecting life includes protecting not only the individual from an act of assisted suicide but society at large. This includes adults subject to undue influence, young people subject to suicide ideation and influenced by societal acceptance of suicide, and society at large subject to a debasing of the value of life and wishing to resist it. Respondents

cannot explain away this critical distinction between the abortion cases and assisted suicide. As a result, the abortion cases do not provide authority for a right to assisted suicide.

2. *Casey* Relied Heavily on Stare Decisis, Which Stands Against an Assisted Suicide Right.

The *Casey* case also provides a poor foundation on which to build other rights because of its heavy reliance on stare decisis to shore up a foundation badly eroded by constitutional scholarship and experience living with the *Roe* formula. The very joint opinion in which Respondents place such trust contains the following comment:

> On the other side of the equation is the interest of the State in the protection of potential life. . . . The weight to be given this state interest, not the strength of the woman's interest, was the difficult question faced in *Roe*. We do not need to say whether each of us, had we been Members of the Court when the valuation of the state interest came before it as an original matter, would have concluded, as the *Roe* Court did, that its weight is insufficient to justify a ban on abortions prior to viability even when it is subject to certain exceptions. The matter is not before us in the first instance, and coming as it does after nearly 20 years of litigation in *Roe*'s wake we are not satisfied that the immediate question is not the soundness of *Roe*'s resolution of the issue, but the precedential force that must be accorded to its holding.

Casey, 505 U.S. at 871 (joint opinion, not for the Court).

The Justices in the joint opinion made it very clear that their reaffirmance of *Roe* was based on their desire to abide by precedent, not on the soundness of *Roe*'s holding. Thus, the abortion precedent is not a sound foundation on which to build a whole new right which has no connection to abortion.[6]

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[6]The erroneous attempt to connect the two by use of abstract language from the joint opinion is discussed *supra*.

In fact, the strong *Casey* reliance on stare decisis has an opposite effect. If *Casey* stands for stability in the law and respect for precedents, it stands against the overreaching and judicial activism Respondents propose in order to create a constitutional right to assisted suicide where state laws have clearly and near-universally condemned the practice.

D. *The Cruzan Case Gives Appropriate Guidance, Including Recognition of a Compelling Interest in Protecting Human Life.*

Respondents also rely on the case of *Cruzan v. Missouri Dept. of Health*, 497 U.S. 261 (1990). *Compassion In Dying*, 79 F.3d at 814. Respondents leap from *Cruzan*'s assumption, for purposes of the case, that there is a liberty interest (not a fundamental right, however) in refusing nutrition and hydration, *Cruzan*, 479 U.S. at 279, to a liberty interest in assisted suicide. *Id.*

While *Cruzan* involves a subject conceptually more applicable to assisted suicide than does the abortion case of *Casey*, close examination of *Cruzan* reveals that it actually leads in a different direction than Respondents attempt to take it. *Cruzan* found that there is an unqualified state interest in protecting individual human life, citing the laws against assisting suicide in support of that interest. *Cruzan*, 497 U.S. at 280. Therefore, what *Cruzan* did not do was to find any fundamental right or liberty interest in committing suicide. The Court did not even speak of a "right to die," referring instead to a "right to refuse treatment" in its discussion of the line of cases involving decisions to forego treatment. *Id.* at 270. Justice Scalia, in his concurring opinion, discussed at length why there is no constitutional right to suicide or assisted suicide. *Id.* at 294-95 (citing Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 25 Duquesne L. Rev. 1 (1985)). The *Cruzan* decision also demonstrated an analysis for finding protected liberty interests, which does not involve the springboard of analogy but involves the careful sort of analysis set forth below, the sort of analysis which must be applied to the case at bar.

Before turning to the appropriate analysis for testing new alleged rights for constitutionality, it should be briefly noted that

the interest in protecting human life is affirmed in other legal contexts, in addition to *Cruzan*. The right to refuse treatment cases uniformly affirm a state interest in preventing suicide. *See, e.g., Tune v. Walter Reed Hosp.*, 602 F. Supp. 1452, 1455 (D.D.C. 1985). In addition, the very criminal law at issue in this case is evidence of the strong state interest in protecting life and preventing suicide, for virtually every jurisdiction bars assisted suicide, as noted by this Court in *Cruzan*. 505 U.S. at 280. In light of the affirmation of *Cruzan* and these cases for a strong state interest in protecting life and preventing suicide, it is clear that no constitutional right to assisted suicide exists.

Given that neither *Casey* nor *Cruzan* establishes a right to assisted suicide, a substantive due process analysis must be conducted to determine whether a right to assisted suicide exists. The appropriate analysis is based on the objective and historically-anchored test discussed *supra*. Respondents have proposed a "right to assisted suicide" which is without basis in any Constitutional provision. Furthermore, any asserted interest in assisted suicide is overruled by several well-recognized compelling state interests in protecting innocent individual human life.

II. UNDER THE APPROPRIATE TEST, THERE IS NO FUNDAMENTAL RIGHT TO ASSISTED SUICIDE.

As described above, the proper analysis for the recognition of a constitutional right to assisted suicide is whether assisted suicide is implicit in the concept of ordered liberty and/or so rooted in the traditions and conscience of our people as to be ranked as fundamental. The test is not whether an individual has a "right to define one's own concept of existence," *Casey*, 505 U.S. at 851, or any other abstract, generalized formulation that would encompass a whole range of legal and illegal behavior. The test is also not some sort of leap by analogy from a right to abortion or to refuse medical treatment to a right to have another person assist one in suicide. The U.S. Constitution does not expressly guarantee any right to commit suicide, so any asserted right must be anchored in some other express right. The possible and proposed rights are considered below. *See also* Bopp, *Is Assisted Suicide Constitutionally Protected?*, 3 Issues in L. & Med. 113 (1987) (hereinafter "*Assisted Suicide*" (discussing and rejecting the asserted rights mentioned below as an asserted basis for a right to assisted suicide at 117-28).

A. *No Constitutional Provision Guarantees a Right to Assisted Suicide.*

Respondents have relied in part on the "right to refuse medical treatment" assumed for purposes of analysis in *Cruzan*, 497 U.S. at 279. *Compassion In Dying*, 79 F.3d 790 at 814. This reliance fails to make the constitutionally-significant distinction between ongoing medical treatment and committing physician-assisted suicide. By basing the analogy on *Cruzan* and the broad "bodily integrity" and "defining one's existence" language of *Casey*, discussed *supra*, a leap is made to asserting a due process right to assisted suicide. As discussed above, framing a proposed fundamental right in such a broad manner is a flawed analysis, and will certainly lead to a flawed result. Indeed, if the right to define one's own existence allows a terminally ill person to have assisted suicide, why would there also not be such a right for persons not terminally ill under that same right. Furthermore, unlike suicide, a refusal of medical treatment may not be motivated by an intent to die. The patient may be balancing the risks and benefits of treatment. *In re Yetter*, 62 Pa. D.&C. 619 (1973) (woman refused biopsy for fear of death in surgery). A procedure with uncertain promise of sustaining life may be refused if the patient feels the benefits do not outweigh the burdens, without the specific intent to die inherent in suicide. *See also Assisted Suicide* at 120 (discussing the common law roots of the right to refuse medical treatment in the concept of battery, which allows rejection of treatment and no more).

Another flaw in the analogy to *Cruzan*'s "right to refuse life sustaining treatment" is that virtually all of the courts have found this right to refuse life-sustaining treatment have also found a compelling interest in preventing suicide. *See, e.g., Tune v. Walter Reed Hosp.*, 602 F. Supp. 1452 (D.D.C. 1985). See also *Assisted Suicide* at 119 n.27 (providing an extended list of cases finding a

compelling interest in preventing suicide). The New Jersey Supreme Court put the matter this way in the case of *In re Conroy*, 98 N.J. 321, 486 S.2d 1209 (1985):

> [D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows a disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.

In re Conroy, 98 N.J. at 350, 486 A.2d at 1224 (citations omitted).

The "right to autonomy" also does not support a right to assisted suicide. Plaintiffs/Respondents and the Ninth Circuit also found a due process liberty interest in "hastening one's own death." *Compassion In Dying*, 79 F.3d at 812. The right to autonomy, often confused with the right to privacy, was best set out by John Stuart Mill, who asserted that, "the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others." John S. Mill, *On Liberty* in 43 Great Books of the Western World 271 (1952). If Mill's assertion is accepted, a law may rightly forbid a physician from doing harm to another, i.e., killing another or assisting another in killing him- or herself. The state may also rightly conclude that endorsing suicide in any situation may cause harm to vulnerable populations, which would also justify a limitation of autonomy with regard to suicide and assisted suicide.

Additionally, when the right to autonomy clashes with the right to life in our constitutional system, the life interest triumphs. This is so because, as Justice Brennan states it, the right to life is the "right to have rights." *Furman v. Georgia*, 408 U.S. 238, 290 (1971) (Brennan, J., concurring). Death is the extinguishment of rights, not the triumph of one right over another. Therefore, any autonomy right to assisted suicide must yield to the right to life. *See also Assisted Suicide* at 125-28 (discussing the autonomy argument).

The right of privacy/ liberty does not encompass a right to assisted suicide. The Ninth Circuit decision relies heavily upon the abortion line of cases culminating in *Casey*, 505 U.S. 833, as support for the right to assisted suicide. *Compassion In Dying*, 79 F.3d at 813-814. Although the joint opinion in *Casey* chose to speak in terms of a fourteenth amendment liberty, the specific aspect of liberty in which the court has relied on since *Roe*, 410 U.S. 113, has been the privacy doctrine. No matter which term is used, however, the test for a fundamental right remains the same.

The analysis described above explains that the proper formulation of the proposed right in this case is whether there is a fundamental right to assisted suicide. Then that query must be submitted to the test of whether a right to assisted suicide is "deeply rooted in this Nation's history and tradition," *Bowers*, 478 U.S. at 192 (quoting *Moore v. East Cleveland*, 431 U.S. at 503 (1977) (opinion of Powell, J.), or "'implicit in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [they] were sacrificed.'" *Id.* (quoting *Palko*, 302 U.S. at 325-26). As the *Bowers* Court stated, these tests are essential to "assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves more than the imposition of the Justices' own choice of values . . . ." *Id.* at 191.

It is clear that a right to assisted suicide is neither implicit in the concept of ordered liberty nor deeply rooted in American history and tradition, for at the time the fourteenth amendment was ratified twenty-one of the thirty-seven states criminalized assisted suicide. Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 25 Duquesne L. Rev. at 76. Those states which did not explicitly recognize assisted suicide as a crime in 1868, did so within the following fifty years. *Id.* at 77-100, 148-242. *See also Special Issue: A Symposium on Physician Assisted Suicide*, 35 Duquesne L. Rev. 1 (1996). In 1973, the U.S. Supreme Court could characterize the laws against assisted suicide as "constitutionally unchallenged," *Paris Adult Theatre I v. Slaton*, 413 U.S. 49 (1973), and in 1990 this Court found there is an unqualified state interest in protecting individual human life, citing the laws against assisting suicide in support of that interest. *Cruzan*, 497 U.S. at

280. *See also Assisted Suicide* at 120-25 (discussing and rejecting an asserted right to assisted suicide and the privacy doctrine).

B. *Compelling State Interests in Protecting Innocent Individual Human Life Overrule Any Asserted Interest in Assisted Suicide.*

Although there is no fundamental right to assisted suicide, even if there were such a right it would be trumped by the existence of compelling state interests in preserving life, protecting third parties, maintaining the ethical integrity of the medical profession (precluding physician involvement), and in preventing suicide. These issues are discussed in sequence below. An excellent resource on ways that a regime of physician assisted suicide would seriously endanger the vulnerable members of our society is The New York Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994).

1. An Interest in Preserving Life Outweighs Any Interest in Assisted Suicide.

Preserving human life is a compelling interest so strong that it even applies to protect viable unborn humans, which this Court in Roe deemed to be only "potential life." *Roe*, 410 U.S. at 163-64. Some courts evaluate this interest only in the context of an individual human, arguing that the interest of the state decreases in relation to the person's prognosis. *See, e.g., In re L.H.R.*, 253 Ga. 439; 321 S.E.2d 716, 723 (1984) ("While the state has an interest in the prolongation of life, the state has no interest in the prolongation of dying . . . ."). Some advocates of assisted suicide argue that if a person waives his or her right to life, the state's interest evaporates. Garbesi, *The Law of Assisted Suicide*, 3 Issues in L. & Med. 93, 107 (1987). It is surely questionable whether one may waive the right to have rights. Is not the right to life "inalienable?"

However, assuming for the sake of argument that the right to life is alienable, the state's interest in life cannot be confined to a single individual. It includes not only the life of the individual but the general societal interest in preserving the inherent sanctity of

human life. Any concession that one person's life has less value, whether by reason of age or disability, is to lessen the value of all life. Moreover such an approach rejects the high constitutional value of equality.

While assisted suicide rights activists urge the recognition of the right for competent adults, there is no constitutionally sound way to confine the right to adults. *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976), recognized that minors have a right to exercise fundamental constitutional rights. Minors would clearly have a right to assisted suicide if it were found to be a fundamental constitutional right. Moreover, recognizing a constitutional right to suicide or assisted suicide would have the effect of signalling societal approval of the act, putting many at increased risk for suicide.

There is also the problem of how to confine the right to assisted suicide to competent persons, for numerous cases since *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), have focused on preserving the constitutional rights of incompetent persons. Via the doctrine of substituted judgment, many incompetent persons would soon be treated to their constitutional right to assisted suicide. The Ninth Circuit acknowledges this likely extension of the assisted suicide right from the logic of their decision. *Compassion in Dying*, 79 F.3d at 823-24. As Judge Reinhardt wrote for the court, "a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." *Id.* at 832 n.120.

The state has a compelling interest in preserving both individual lives and the sanctity of human life. This compelling interest overrides any constitutional interest, liberty, or fundamental right to assisted suicide. *See also Assisted Suicide* at 129-32 (discussing at length the state interests in preserving life).

2. An Interest in Protecting Third Parties Outweighs Any Interest in Assisted Suicide.

The state also has a compelling interest in protecting third parties. For example, parents have duties of support to their children which are legaily enforceable. Debtors have legal duties to creditors. Of course, in addition to legal debts, there are moral debts members of society owe to others. If society may prohibit an individual from escaping his or her legal debts in other ways, why may a state not do so by prohibiting suicide? The courts have considered this interest too narrowly, considering only the presence or absence of minor children who will be affected. *See, e.g., St. Mary's Hosp. v. Ramsey*, 465 So. 2d 666, 668 (Fla. Dist. Ct. App. 1985) (finding no abandonment of child because primary residence was with other parent and patient had purchased annuity naming child as beneficiary). However, third parties may be more profoundly affected by suicide than by other cases leading to the death of a parent. One woman wrote about her mother's suicide:

> Suicide is not a normal death. It is tragic beyond the most shattering experiences, and the ultimate form of abandonment. There is no fate on which to place the blame. It rests squarely on the shoulders of the victim and the people left behind, many of whom spend the rest of their lives wondering if there was anything they could have done to prevent such a tragedy.

Scheinin, *The Burden of Suicide*, Newsweek, Feb. 7, 1983, at 13.

Because suicide is a social act, communicating to other people, the state has a strong interest in protecting innocent parties from such infliction of distress.

3. An Interest in Preserving and Maintaining the Ethical Integrity of the Medical Profession Outweighs Any Interest in Assisted Suicide.

Society also has a compelling interest in opposing physician involvement in assisted suicide, something many assisted suicide advocates envision. Allowing assisted suicide directly places the healing profession of medicine into the business of killing. As the *Quinlan* court observed, the conduct of the medical profession

"must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgments of the community at large." *Quinlan*, 70 N.J. at 44, 355 A.2d at 665. That physicians, who are supposed to be healers, must not become killers, was thought to be resolved millennia ago with the Hippocratic Oath, which bars giving "deadly medicine to anyone," and begins, "First, do no harm." Hippocrates, *The Medical Works of Hippocrates* 9 (trans. J. Chadwick & W. Mann, 1950). The Hippocratic bar against physician involvement in killing of any sort is vital, as explained by anthropologist Margaret Mead:

> For the first time in our tradition, there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with the power to kill had the power to cure, including specially the undoing of his own killing activities. He who had power to cure would necessarily also be able to kill. With the Greeks, the distinction was made clear. One profession, the followers of Asclepias, were to be dedicated completely to life under all circumstances, regardless of rank, age, or intellect the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child. . . . This is priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. It is the duty of society to protect the physician from such requests.

Levine, *Psychiatry and Ethics* 377 (1972) (personal communications from Margaret Mead), quoted in Hilgers & Horan, *Abortion and Social Justice* 310-11 (1972).

Another problem with allowing physicians to assist in suicide is that physicians would soon feel a legal duty to routinely advise patients of the suicide option to avoid legal liability. This would not only have the effect of increasing assisted suicides but would complete the transformation of the physician to a routine killer. *See also Assisted Suicide* at 133-35 (discussing the topic of this subsection at greater length).

4. An Interest in Preventing Suicide Outweighs Any Interest in Assisted Suicide.

Finally, the states have a highly relevant compelling interest: the prevention of suicide. Virtually all the courts considering withdrawal or refusal of treatment cases have recognized this compelling interest. *See, e.g., Tune v. Walter Reed Hosp.*, 602 F. Supp. at 1455. *See also Assisted Suicide* at 136 n.100 (listing numerous cases which have recognized this interest).

One of the grounds for this interest is the state's interest in protecting persons with mental disorders. Ninety-three to ninety-four percent of persons who have committed suicide are believed to have suffered from mental disorders. Robins, *The Final Month* 12 (1981) (94%); Baraclough, Bunch, Nelson & Sainsbury, *A Hundred Cases of Suicide: Clinical Aspects*, 125 Brit. J. Psych. 355, 358 (1974) (93%). Although many persons with mental disorders will not be capable of rational decisionmaking, *Assisted Suicide* at 137 & notes (discussing the effect of certain mental disorders), they would not necessarily be judged legally incompetent. For example, the numerous followers of the Rev. Jim Jones who committed mass suicide in Guyana in 1978 were not likely to have been declared legally incompetent. *See* Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 25 Duquesne L. Rev. at 142-45. Efforts to restrict suicide to voluntary, competent adults would certainly sweep in many persons who were possessed of irresistible psychological predispositions to suicide.

Moreover, many persons who attempt suicide do not simply wish to die. The suicide attempt may often be an appeal for help, a blackmail attempt, an effort at escape, an expression of aggression, or a form of self-punishment. Ruebenstein, Moses & Lidz, *On Attempted Suicide*, 79 Arch. Neurol. & Psych. 103 (1958). Such attempts need to be greeted with intervention, not an offer of assistance in suicide. If not, a large population which could have been helped would die. The state has a clear, compelling interest in protecting this vulnerable population.

Society also has a compelling interest in resisting manipulated suicides. Were suicide to become common, persons considered

"burdens" on relatives would feel considerable pressure to be assisted in ceasing to become burdens. This risk, and the risk of substituted judgment assistance in suicide would extend to persons in nursing homes, mental institutions, and group homes for persons with mental and emotional difficulties.

Finally, as John Stuart Mill observed, society has an interest in the contribution of each member of a society, for "everyone who receives the protection of society owes a return for the benefit," which includes "not injuring the interests of another" and "bearing his share . . . of the labours and sacrifices incurred for defending the society or its members. . . . [W]hen a person disables himself, by concept of purely self-regarding, from the performance of some definite duty incumbent on him to the public, he is guilty of a social offense." John S. Mill, *On Liberty* in 43 Great Books of the Western World at 302-03, 306. Suicide disables a person forever of rendering any contribution to society. *See also Assisted Suicide* at 135-40 (discussing this subject in greater depth).

CONCLUSION

In sum, there is no fundamental right to assisted suicide, and, even if there were, there are ample compelling interests which would justify the State of Washington in proscribing assisted suicide. Vulnerable members of society deserve more from a culture which desires to consider itself civilized and humane than assistance or encouragement in the annihilation of all of their rights by self-destruction.

For the above reasons, your *amici* respectfully pray this Court (1) to hold that there is no right to assisted suicide in the Constitution of the United States, and (2) to reverse and/or vacate the decision of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, ATTORNEY GENERAL OF WASHINGTON,

Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, MD. PH.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE LEGAL CENTER FOR DEFENSE OF LIFE, INC. AND THE PRO-LIFE LEGAL DEFENSE FUND IN SUPPORT OF PETITIONERS

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Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE LEGAL CENTER FOR THE DEFENSE OF LIFE, INC. AND PRO-LIFE LEGAL DEFENSE FUND IN SUPPORT OF PETITIONERS

This *amici curiae* brief respectfully is submitted on behalf of The Legal Center for Defense of Life, Inc. and The Pro-Life Legal Defense Fund, Inc. in support of Petitioners and in favor of reversal of the judgment of the United States Court of Appeals for the Ninth Circuit entered on March 6, 1996. Pursuant to Rule 37.3 of the Rules of this Court, *Amici* have obtained and file herewith the written consent of each of the parties to the filing of this brief.

Amici submit that the inadequate historical analysis undertaken by the majority opinion in the *en banc* decision of the Court of Appeals for the Ninth Circuit requires this Court to reverse the judgment below and direct the dismissal of the underlying complaint. Any other result will further undermine the public's confidence in the ability and willingness of institutions of government, and in particular the federal Judiciary, to protect them and future generations in their "inalienable rights."

INTEREST OF THE AMICI CURIAE

The Legal Center for Defense of Life, Inc. (the "Legal Center") is a New York not-for-profit corporation which provides pro bono legal services to those engaged in the defense of the sanctity of all human life from conception to natural death. The Pro-Life Legal Defense Fund, Inc. (the "Fund") is a Massachusetts not-for-profit corporation which provides *pro bono* legal services to those engaged in the defense of the sanctity of all human life from conception to natural death. Among the clients of the Legal Center and the Fund are medical professionals who oppose the culture of death which so pervades contemporary American society.

SUMMARY OF ARGUMENT

The majority opinion below failed to follow this Court's clear mandate in *Bowers* v. *Hardwick*, 478 U.S. 186 (1986), since its meager historical analysis did not give proper weight to the relevant legal history with respect to assisted suicide in the United States. The majority also distorted its already inadequate historical analysis in an attempt to justify its unauthorized creation of a new fundamental right.[1] An

[1] A fuller version of the historical argument contained in this brief is contained in the forthcoming issue of the Harvard Journal of Law and Public Policy in an article entitled "The Use and Abuse of History in *Compassion in Dying*" by Dwight G. Duncan and Peter Lubin.

honest review of the history of assisted suicide in Western culture leads to the conclusion that no such right should be recognized.

ARGUMENT

I.

THE COURT OF APPEALS FAILED TO FOLLOW THE DIRECTIVES OF *BOWERS* V. *HARDWICK* IN FINDING A FUNDAMENTAL CONSTITUTIONAL RIGHT TO PHYSICIAN-ASSISTED SUICIDE

In *Bowers* v. *Hardwick*, 478 U.S. 186 (1986), this Court refused to find a fundamental constitutional right to homosexual sodomy, requiring that for such rights, "which are not readily identifiable in the Constitution's text, to be found they must be "either implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed" or "liberties that are deeply rooted in the nation's history and traditions." 478 U.S. at 191-92.[2] This Court properly identified the danger of reckless invention of new fundamental rights:

> "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930s, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those

[2] *See also Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977); *Palko* v. *Connecticut*, 302 U.S. 319, 325-26 (1937).

Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority." *Id.* at 194-95.

Whenever this Court has failed in this task, the cause of individual human rights has declined and public respect for the Judiciary has concomitantly diminished.[3]

The majority opinion below, while purporting to comply with the directives of this Court in *Bowers*, fails to do so in three fundamental respects. First, the discussion of history is remarkably brief, comprising only four pages of a fifty-one page opinion, 79 F.3d at 806-810, suggesting that the majority did not view this historical analysis as particularly important. Second, the court of appeals inquired not into the historical view of physician-assisted suicide—the obviously relevant area of inquiry—but rather into "Historical Attitudes toward Suicide". 79 F.3d at 806. Finally, the inquiry is at best half-hearted, since the majority apparently believed that the failure of the historical evidence to support a position is alone "not a sufficient basis for rejecting a claimed liberty interest." 79 F.3d at 805. The result is precisely the sort of judicial creation of new fundamental rights that this Court counseled against so strongly in *Bowers*. Moreover, as we discuss in Point II, the majority opinion below seriously distorts the true historical record, which unequivocally supports a continuation of the legal proscription against assisted suicide, as the dissent below points out. 79 F.3d at 850.

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[3] Without unnecessarily multiplying citations, one has only to refer to the majority opinions in the following cases: *Scott* v. *Sandford*, 60 U.S. (19 How.) 393, 15 L.Ed. 191 (1856); *Bradwell* v. *Illinois*, 83 U.S. (16 Wall.) 130, 21 L.Ed. 442 (1873); *Minor* v. *Happersett*, 88 U.S. (21 Wall.) 162, 22 L.Ed. 627 (1875); *Plessy* v. *Ferguson*, 163 U.S. 537, 41 L.Ed. 256, 16 S.Ct. 118 (1896); *Korematsu* v. *United States*, 323 U.S. 214, 65 S.Ct. 193, 89 L.Ed. 194 (1944).

II.

THE MAJORITY OPINION DISTORTS THE HISTORICAL RECORD IN AN APPARENT ATTEMPT TO JUSTIFY ITS CREATION OF A NEW FUNDAMENTAL CONSTITUTIONAL RIGHT

Even accepting the majority's assertion that the relevant historical inquiry is the public attitude toward suicide—which is plainly not the issue at all—the court's analysis is both incomplete and inaccurate. Thus in referring to antiquity, the majority fails to mention the most relevant single piece of historical evidence—the Hippocratic Oath.

The Hippocratic Oath

Curiously, there is no mention of the Hippocratic Oath in the majority's historical analysis, and the Oath is instead discussed in another section of the opinion[4]. Yet the language of the Oath, composed in classical antiquity, clearly forbade doctors from administering lethal drugs to patients, even if requested, as it forbade their even suggesting such a course.[5] The Hippocratic Oath was administered throughout the Western world for millennia; whatever one now makes of its original formulation, as survey devoted to "historical attitudes toward suicide" cannot avoid the one piece of historical evidence which is most directly relevant to the question. It

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[4] In another section of the majority opinion, the court notes that the Hippocratic Oath, in its view, is no longer relevant, because according to the court the Oath also forbade abortion. 79 F. 3d at 829. The logic is: abortion is allowed despite the Hippocratic Oath; ergo, physician-assisted suicide should also be allowed. But this does not logically follow.

[5] OATH, 1 HIPPOCRATES 299 (1957) (W.H.S. JONES, trans.) ("I will use treatment to help the sick according to my ability and judgment, but never with a view to injury and wrong-doing. Neither will I administer a poison to anybody when asked to do so, nor will I suggest such a course.")

expressly forbids the giving of poisons to patients even when requested—a clearer rejection of physician-assisted suicide cannot be imagined. What is important is not only the Oath itself, but its wide acceptance, in so many countries, over so long a period, as the solemn accompaniment to full-fledged admission to the profession of medicine.

The undeniable relevance of the Hippocratic Oath's undertakings can be seen from the American Medical Association's Code of Ethics, as Judge Beezer notes in his dissent:

> "While not legally binding, the AMA Code of Ethics provides clear guidance on the current position of medical ethicists. Section 2.211 of the American Medical Association's Code of Medical Ethics and Current Opinions of the Council on Ethical and Judicial Affairs ('AMA Code of Ethics') prohibits physician participation in physician assisted suicide. In virtually identical language to its condemnation of euthanasia, section 2.211 provides:
>
> 'Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g. the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). -
>
> 'It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, *allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.*' (Emphasis added)"

79 F.3d at 855 (Beezer, J., dissenting).

Nor does the superficial survey of history in the majority opinion, aside form the short shrift given the Hippocratic Oath, inspire greater confidence.

Literary Suicides

In assessing the accuracy and completeness of the majority opinion's historical survey, our task is simplified by the fact that the majority relies on only a handful of secondary sources, never the original texts themselves. Indeed, fully half of the footnotes in the survey refer to a single article, Marzen, et al., *Suicide: A Constitutional Right*, 24 Duq. L. Rev. 1 (1985) (hereinafter "Marzen"). Moreover, the majority's historical "analysis" begins by confounding history and literature:

> "[I]n Greek and Roman times, far from being universally prohibited, suicide was often considered commendable in literature, mythology, and practice."

79 F.3d at 806. Hence, in this "historical" survey, the majority starts with "the first of all literary suicides," Jocasta, who, the court says, chose "an honorable way out of an insufferable situation." *Id.* at 806. As for Homer, the majority comments that he "records self-murder without comment, as something natural and heroic [and the] legends bears him out." *Id.* One legend is offered, presumably by way of example: "Aegeus threw himself into the sea—which therefore bore his name—when he mistakenly thought his son Theseus had been slain by the Minotaur." This effort is breezily done, of course—no doubts, no weighing of evidence, as this Court plainly mandates, *Bowers* v. *Hardwick*, *supra*. Yet, aside from the eponymous tale of How The Aegean Got Its Name, how many Greek myths can the majority adduce in support of the proposition that the Greeks regarded suicide tolerantly? Is it proper historical analysis to derive such a conclusion from that—or any—legend?

As for Jocasta, neither her suicide, nor that of any other literary character, whether deplorable or admirable, can be

adduced to prove anything other than what all sensible people already know—that sometimes, feeling desperate or hopeless, people will kill themselves. Jocasta and Aegeus do not exhaust the list. But it is poor scholarship to claim that Cleopatra affixing that reluctant asp to her breast, or Emma Bovary poisoning herself *en provence*, or Anna Karenina throwing herself under a St. Petersburg train, can tell us whether or not Elizabethan England, France under the Second Republic, or Czarist Russia, respectively, regarded suicide as noble or ignoble, practiced only by the very great or only by the very foolish. The majority's uses of ancient history are no more reliable.

Ancient History

One might have expected the majority opinion to have begun its survey with the Hebrews. The contribution of ancient Israel to Western civilization includes Monotheism and the moral code enshrined in the Ten Commandments. The Torah, as well as the traditions and legends of the Jewish People, have helped to form Western attitudes toward suicide. Yet, aside from one footnote of two sentences, one each for the Old[6] and the New Testaments, the majority devotes to all of ancient Israel's history, religion, and moral teachings not a paragraph, but a single sentence in another footnote: "Hundreds of Jews killed themselves at Masada in order to avoid being captured by Roman legions." *Id.* at 20 n. 24. This well-known fact, of course, tells us nothing about the accepted attitude toward suicide in ancient Israel.

In contrast, if one turns back to Marzen, the article the majority uses with such assiduity when it supports their preconceived conclusions, we find quite a different story. Marzen

[6] In that footnote, the majority states: "the stories of four suicides are noted in the Old Testament—Samson, Saul, Abimlech [*sic*], and Achitophel—and none is treated as an act worthy of censure." 79 F.3d at 808n.25.

finds in the Old Testament, and lists, not four but eight suicides, and notes that

> "with the exception of Samson, none of the eight who died by suicide are presented as heroes. . . . Only Samson's suicide was arguably heroic. . . . Since Samson does not appear directly to will his own death, but only the death of the Philistines at the cost of his own life, his intention is arguably not even suicidal."

Marzen at 19.

Marzen quotes several scholars on the subject as well. Hankoff, in *Judaic Origins of the Suicide Prohibition,* observes that "suicide was a rare phenomenon in Biblical times"; another scholar notes that "those that did commit suicide were considered deranged"; a third says that "[w]hen the act did occur, the victim and his family were punished by denial of a regular burial and the customary rituals of mourning." Marzen at 20. As time went on, Jewish writers more explicitly formulated their ideas on suicide:

> "As the influence of Hellenism spread, Jewish writers developed a more philosophic posture and became more explicit in their treatment of moral problems such as suicide. The earliest known formal prohibition of suicide among the Jews occurred in the first century A.D., when Josephus, after his army had been conquered by the Romans, forbade his soldiers to kill themselves on the grounds that suicide was a cowardly act, contrary to nature and the law of God, who committed man's soul to his body. Josephus' order contrasted with that of Eleazer Ben Jair, who successfully urged his Zealot followers to commit mass suicide at Masada in order to avoid capture by the Romans. After the exile, prohibitions of suicide were included in the Rabbinic and Talmudic writings, expressed in stories and in mourning and funeral sanctions."

Id. It is at least curious that the majority opinion sees fit to ignore all of this obviously relevant history.

Regardless of whether there are four or eight instances of suicide in the Old Testament[7], and whether, as the majority asserts, "none is treated as an act worthy of censure," there is a dramatically censured instance of assisted suicide or mercy killing—Saul, the first King of Israel, which Marzen, the majority's principal source,also recounts. Marzen at 19. As a scholar recounts it,

> "Saul was badly wounded in battle by a Philistine arrow. Afraid of being tortured and humiliated by his captors, he pleaded with his armour-bearer to kill him (I Sam 3:1-5; I Chron 10:1-4). There are two versions of what happened next. According to the first, the man refused, so Saul committed suicide by falling on his own sword (I Sam 31:5-6: I Chron 10:4). In the other account a young Amelikite came upon the wounded Saul leaning on his spear, perhaps attempting suicide. Saul begged him, Stand beside me and slay me, for anguish has seized me and yet my life lingers. So the youth obliged (2 Sam 1:6-10) in what today we would call an act of voluntary euthanasia, assisted suicide or mercy killing."[8]

This scholar concludes: "Yet the undoubted conclusion of this story is that despite being done with the best will in the world, this was none the less a wicked act, deserving the severest of punishments." *Id.* at 316. When David heard the news from the Amelikite, he "rent his garments. . . mourned and wept, and fasted" (2 Sam 1:11-12). "Then he bade one of his men go up and make an end of the Amelikite, and when the blow had

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[7] *Compare* the majority opinion, 79 F.3d at 808 n.25 *with* Judge Beezer's dissent, *id.* at 845.

[8] Anthony Fisher, Theological Aspects of Euthanasia, in Euthanasia Examined: Ethical, Clinical and Legal Perspectives (Cambridge Univ. Press 1995) at 315-16.

fallen, said over his dead body, Such is thy reward for owning thyself the murderer of an anointed king." (2 Sam 1: 15-16).

One would expect nothing less of a tradition that gave the world the Decalogue, with its categorical "Thou shalt not kill" (Exod 20: 13; Deut 5:11). According to the Anchor Bible, this commandment "is formulated in the most absolute manner, without specifying the object of the crime, in order to include any possible object, any human being (including suicide)."[9]

Of course, in the New Testament, Judas commits suicide. But he is not exactly held up as a role model, either, except in the revisionist Biblical history of Judge Reinhardt, where "the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance." 79 F.3d at 808 n.25. This is absurd exegesis. As Raymond Brown says in his *Death of the Messiah*:

> "the Jewish attitude toward suicide as infringing on God's rights makes it extremely unlikely that Judas' hanging himself would have been considered a divinely acceptable expiation. To those who say that for various reasons it is noble to destroy oneself, Josephus (War 3.8.5) replies with indignation, "it is an act of impiety towards God who created us."[10]

The Greeks

The majority opinion's treatment of the Greeks does not inspire any greater confidence. First, Judge Reinhardt says that "in Athens, as well as the Greek colonies of Marseilles and Ceos, magistrates kept a supply of hemlock for those who wished to end their lives. The magistrates even supplies those who wished to commit suicide with the means to do so." 79 F.3d at 807. This is taken from Durkheim's *Suicide*. But

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[9] MOSHE WEINFELD, DEUTERONOMY 1-11 (1991).

[10] RAYMOND BROWN, 1 DEATH OF THE MESSIAH 644 (1991).

immediately above the passage quoted by the majority, the following appears in Durkheim:

> "Suicide was only considered illegal if it was not authorized by the state. Thus at Athens a man who had killed himself was punished with *'atimia'* [dishonor] for having committed an injustice to the city; the honors of regular burial were denied him; also his hand was cut from his body and buried separately. It was the same at Thebes with variations in detail, and also at Cyprus. The rule was so severe at Sparta that Aristodemus was punished for the way he sought and found death at the battle of Plataea."[11]

The majority's treatment of Greek philosophy is equally suspect. Judge Reinhardt gives the pre-Socratics short shrift, citing the Court's decision in *Roe* v. *Wade*:

> "In *Roe*, while surveying the attitudes of Greeks toward abortion, the Court stated that 'only the Pythagorean school of philosophers frowned on the related act of suicide,' 410 U.S. at 131, . . . ; it then noted that the Pythagorean school represented a distinctly minority view."

79 F.3d at 807.

In quoting this Court in *Roe*, the majority below passes over Plato and Aristotle. While it is natural that the discussion should turn first to Socrates, whom some consider the most famous suicide in history, it must be remembered that Socrates was under a death sentence. He took hemlock rather than flee Athens or be killed by the state. Not everyone would consider this a classic suicide; some might consider it rather enforcement of the state's punishment. It is humanly understandable that we are, in some sense, "impressed" with the

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[11] E. DURKHEIM, SUICIDE: A STUDY IN SOCIOLOGY 330 (Spaulding & Simpson, trans., 1952).

obstinate bravery and self-sacrifice of the warriors at Masada, or Socrates' willingness to die rather than be exiled, but this is very far from extrapolating, from these facts alone, societal approval of suicide. Yet this is the faulty reasoning adopted by the majority below. Moreover, Judge Reinhardt selectively uses his sources to shape history.

Thus, the majority writes that "while Socrates counseled his disciples against committing suicide, he willingly drank the hemlock as he was condemned to do, and his example inspired others to end their lives." *Id.* One is apparently expected to conclude from this that suicide met with approval in ancient Greece. The majority does nothing to dispel this impression, telling us that "Plato, Socrates' most distinguished student, believed suicide was often justifiable," citing Durkheim. Id. at 807 n.22.

But in Marzen, a source which the majority eschews here, the discussion of *Phaedo*, Plato's narrative of Socrates' last hours, comes up with quite a different conclusion:

> "Socrates compares the human relationship to the gods with that of slave to master, all humans are the possession of the gods, and none have the right themselves to dispose of their lives. Moreover, to commit suicide would provoke the anger of the gods and would thus entail consequent punishment. Even though the choice of death seems preferable to life in some cases, suicide is not morally justified. . . . In the time of Socrates, suicide is deemed immoral not simply because it violates the 'property rights' of the gods, but because it undermines the attainment of ultimate happiness."

Marzen at 22. Marzen looks elsewhere in Plato as well:

> "In the *Laws*, Plato addresses the problem of suicide in the context of the individual's relationship with the social order. His treatment of the matter there can best be understood in light of the ethics he developed in the

Republic and the *Timaeus*. In those works, Plato stressed an organic interrelationship between the individual person, the state, and the universe, morality ultimately being a matter of the human soul's disposition in the cosmic order. . . . Plato's public policy on suicide stated in the *Laws* presumes this ethical and cosmic perspective. In the *Laws* Plato observes of suicides that '*the graves of such as perish must, in the first place be solitary; they must have no companions whatsoever in the tomb. Furthermore, they must be buried ignominiously in waste and nameless spots . . . and the tomb shall be marked by neither headstone nor name.*' " (Emphasis added)

Marzen at 23 n.132. Marzen sums up that Plato

> "is concerned with suicide as a deliberate and reasoned decision, rather than as the result of passion, compulsion, or madness. In the latter cases, culpability is lacking and the fault of malice against society is not assumed; hence the state, while not condoning such action, suspends its judgment. *But when suicide is a rational and deliberate choice, it is deemed to be a flagrant act of contempt for the state and an abandonment of duty to society and the divine order.*" (Emphasis added)

Marzen at 24. This fair examination of the *Phaedo*, the *Laws*, and the ethical system developed in the *Republic* and the *Timaeus*, gives a view quite different from the desultory paragraph devoted by the majority to Plato.

If the majority's treatment of Plato can be criticized, the discussion of Aristotle can not—but only because, in what purports to be a serious review of Greco-Roman culture, Aristotle is not even mentioned! Again, had the majority consulted Marzen, their selective source of choice, they would have found a strong contradiction to the conclusions expressed in their summary. Thus, Marzen identifies Aristotle as one who unconditionally condemned suicide. Marzen

explains that Aristotle, like Plato, believed that the individual has a moral obligation to serve the society:

> "The law does not allow a man to kill himself. . . when a man voluntarily—that is, knowing who the victim and what the instrument is—injures another (not by way of retaliation) contrary to law, he is acting unjustly. But a man who cuts his throat in a fit of anger is voluntarily doing, contrary to right principle, what the law does not allow; therefore, he is acting unjustly, but towards whom? Surely not himself, but the state; because he suffers voluntarily, and nobody is voluntarily treated unjustly. It is for this reason that the state imposes a penalty, and a kind of dishonor is attached to a man who has taken his own life, on the ground that he is guilty of an offence against the state."

Marzen at 24, citing Aristotle, ETHICS, 200-01 (J. Thompson trans. 1977). In sum, as Marzen notes, suicide "as an act of cowardice, was deemed a rejection of one's personal duty, both to society and to oneself. *Id.*

No doubt the emphasis on the collective, on the duty of the individual to society, is foreign, even antipathetic to, modern ears. But if the history of Western attitudes toward suicide is to be our guide, then passing over Aristotle is exceedingly strange.

Roman Law

In discussing Rome, the majority acknowledges that "Romans did sometimes punish suicide, but notes that in the case of those accused of crime, the deceased's property would escheat to the state unless the suicide was caused by impatience of pain or sickness." 79 F.3d at 808. While this recitation does suggest an opening for what we would call physician-assisted suicide, the majority fails to note the punishment of the *Lex Cornelia* on murderers and poisoners:

> "someone is liable who kills any man. . . he is also liable who makes up [and] administers poison for the purpose of killing a man. . . . Someone is punished who makes, sells, or possesses a drug for the purpose of homicide."[12]

It certainly appears that the person who supplies the lethal drug would fall within the proscription of Roman law, regardless of how the individual suicide would be viewed. Gaius had recognized that "even medicine is poison."[13] In other words, regardless of how it treated the individual person who committed or attempted suicide, when it came to assisting suicide, Roman law came down exactly where the Hippocratic Oath did. A recent treatise on *The Criminal Law of Ancient Rome*, analyzing Roman law, concluded that while suicide itself was not generally a crime, "a mercy killing would still have counted as murder."[14]

Roman law also provided that "Guilty intention could be presumed from the deed, which need not be direct, for furnishing the cause of death was expressly provided for."[15] Justinian's *Institutes*, commenting on the *Lex Cornelia*, says, "This statute also inflicts punishment of death on poisoners, who kill men by their hateful arts of poison and magic, or who publicly sell deadly drugs."[16]

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12 DIG., 48.8.1, 3 (Marcian, Institutes 14) (Alan Watson trans. ed., Univ. of Pennsylvania Press 1985).

13 DIG., 50.16.236 (Gaius, XII Tables, 4).

14 O.F. ROBINSON, THE CRIMINAL LAW OF ANCIENT ROME 44 (1995).

15 *Id.*, citing DIG. 48.8.15, which says: "It makes no difference whether someone kills or provides the occasion of death." [*nihil interest, occidat quis ad causam mortis praebat.*]

16 JUSTINIAN INSTITUTES 4.18.

The Middle Ages

In the Christian world, at the end of antiquity, St. Augustine represented, as the dissent below notes, a clear and unambiguous voice of the tradition against self-killing, viewing it a simple application of one of the ten commandments, "Thou shalt not kill." 79 F.3d at 845 (Beezer, J. dissenting), (citing Marzen at 27). The majority "explains" Augustine's opposition as "prompted in large part by the utilitarian concern that the rage for suicide would deplete the ranks of Christians, St. Augustine argued that committing suicide was a detestable and damnable wickedness and was able to turn the tide of public opinion." 79 F.3d at 808. In fact, there is no reference made to any work of Augustine to substantiate this claim. If Augustine were such a utilitarian, and since suicide was a practice of his Donatist opponents, presumably he would not have objected to *their* use of suicide, but he clearly did object. It is therefore implausible to suggest that his opposition to suicide was prompted by utilitarian considerations.

Another example of the pseudo-scholarship indulged in by the majority opinion is the citation to St. Thomas More, described as "later canonized by the Roman Catholic Church," as "strongly support[ing] the right of the terminally ill to commit suicide and also express[ing] approval of the practice of assisting those who wished to end their lives" in his book *Utopia*.[17] While interpretation of Utopia is admittedly difficult, the Majority's source fails to note that the pro-suicide talk comes from the character Hythlodaeus, whose name literally means "speaker of nonsense," while the character named "Thomas More" strongly disagrees with those views.

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17 79 F.3d at 808, citing Thane Joseph Messinger, *A Gentle and Easy Death: From Ancient Greece to Beyond Cruzan Toward a Reasoned Legal Response to the Societal Dilemma of Euthanasia*, 71 Denv. U.L. Rev. 175, 185-88 (1993).

Professor Gerard Wegemer of the University of Dallas, author of a recent biography of More and of a study of his writings on statesmanship,[18] has informed us that to assert that Thomas More supported the rights of the terminally ill to commit suicide is equivalent to saying that Jonathan Swift in his *Modest Proposal* supported the right to kill Irish babies in order to provide food and fine gloves for English aristocrats. Both works are satires. Moreover, *Utopia* is an early work of More. At the end of his life, while awaiting his execution in the Tower of London, More wrote *A Dialogue of Comfort against Tribulation* which devotes a lengthy passage of remarkable subtlety and perception to the ways to cure a person tempted toward suicide.

The English Common Law—Bracton

While one might expect the majority opinion's scholarship to improve in considering the English Common Law, one again finds instead distortion and incompleteness of analysis. Thus, the majority's treatment of Bracton, a major figure in the development of the English Common Law, is of a piece with the slipshod character of the entire historical survey. The majority asserts that Bracton's innovation on Roman law was in the direction of injecting a greater understanding and compassion for the person who committed suicide from inability "to endure further bodily pain." 79 F.3d at 808-09. Yet the majority had earlier quoted Alvarez on Roman law itself, *i.e.*, Justinian's *Digest*, to the effect that "suicide of a private citizen was not punishable if it was caused by 'impatience of pain or sickness, or by another cause,' or by 'weariness of life. . . lunacy, or fear of dishonor.' " *Id.* at 807.

In fact, the innovation of the Common Law with respect to suicide was two-fold: (a) to punish all suicides of sane people, rather than just those of certain classes (*i.e.*, those

[18] GERARD B. WEGEMER, THOMAS MORE: A PORTRAIT IN COURAGE (1995); THOMAS MORE ON STATESMANSHIP (1996).

accused of crime, soldiers, slaves), and (b) to provide the penalty of confiscation of personal property to those suicides that were motivated by impatience of pain or weariness of life, while in the absence of such motivation the suicide's real property would be forfeit as well. It is hard to see either of these developments beyond Roman law as treating "suicides resulting from the inability to 'endure further bodily pain' with compassion and understanding." *Id.* at 809.

This distortion of Bracton illustrates the shaky foundations of the majority opinion's purported historical survey of attitudes toward suicide, which rubric it apparently borrowed from its selective source of choice, Marzen. While the majority offers three footnotes to Marzen in this section, the excerpt from Marzen on which it relies (Marzen at 57-58) is belied by the original sources. Under Roman law, as Marzen's own discussion showed, a sane suicide's property, whether personal or real, would *not* be forfeited. Only those "who have been arraigned or who have been caught red-handed, and have committed suicide from fear of the impending charge," would forfeit their personal property, as Marzen noted in the passage relied upon by the majority.[19] Moreover, as the majority and Marzen recognized, land was not generally forfeitable under Roman law. In other words, under Justinian, someone who committed suicide, not because he had been accused of crime but for a cause which included "pain of some description" or "weariness of life," would not forfeit either personal property or land. Thus Bracton's innovation makes the legal position of the ordinary suicide worse than under Roman law. The treatment of suicide under the English Common Law, as one can see in Blackstone, was to steadily become even more severe.

[19] Marzen at 57-58.

Coke and Blackstone

After Bracton, the next paragraph in the majority opinion is devoted to Sir Edward Coke, who, the opinion correctly observes, held that killing oneself was an offense and that one who committed it should forfeit his personal property. However, the majority here employs various rhetorical devices to minimize what an incautious reader could be excused for missing—the fact that in the English Common Law there was a firm prohibition on suicide by the sane. Here is how the verbal sleight of hand is performed:

> "Thus, although formally, suicide was long considered a crime under English common law, in practice it was a crime that was punished leniently, if at all, because juries frequently used their power to nullify the law."

79 F.3d at 809. Yet as Justice Scalia wrote in his concurring opinion in *Cruzan*, "the States abolished the penalties imposed by the common law . . . to spare the innocent family and not to legitimize the act." 497 U.S. at 294. This is very different from approving of suicide, and, much less, of course, physician-assisted suicide, or thinking of it as a right.

The very next paragraph of the majority opinion deploys to even greater effect the vocabulary of belittlement:

> "The traditional English experience was also shaped by the taboos that have long colored our views of suicide and perhaps still do today. English common law reflected the ancient fear that the spirit of someone who ended his own life would return to haunt the living."

79 F.3d at 809. Note the language intended to evoke a pre-rational world of credulous peasants: views are shaped by "taboos" that have "long colored our views of suicide." And we are apparently to infer that those credulous peasants have their counterparts in those benighted souls who continue to regard suicide with horror—*i.e.*, those who differ with the majority's views on physician-assisted suicide: these are the people for

whom those ancient "taboos . . . perhaps still [color their views] today." And then the majority opinion becomes positively Transylvanian:

> "Accordingly, the traditional practice was to bury the body at a crossroads—either so the suicide could not find his way home or so that the frequency of travelers would keep his spirit from rising. As added insurance, a stake was driven through the body."

Id.

The reader would presume from this sort of tone, that none of those who over so many centuries had produced so many coherent arguments against suicide had ever existed—or that they should be treated, or tainted with a guilt by verbal association, with slack-jawed rustics practicing a bit of apotropaic mumbo-jumbo. Even sticking to the English experience, it is a bizarre circumstance that at this point, where the majority cites Blackstone's *Commentaries* in a footnote, *Id.* at 809n.38. If the Ninth Circuit had bothered to look into those *Commentaries*, they would have found that Blackstone, certainly the most influential legal figure in Anglo-American law from the Revolutionary War to the Civil War, expresses no ambiguity or doubt about where the English Common Law then stood on this matter:

> "SELF-MURDER, the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure, though the attempting it seems to be countenanced by the civil law, yet was punished by the Athenian law by cutting off the hand, which committed the desperate deed. And also the law of England wisely and religiously considers, that no man hath a power to destroy life, but by commission from God, the author of it: and, as the suicide is guilty of a double offence; one spiritual, in invading the prerogative of the Almighty, and rushing into his immediate presence uncalled for; the

other, temporal, against the king, who hath an interest in the preservation of all his subjects; *the law has therefore ranked this among the highest crimes*, making it a peculiar species of felony, a felony committed on oneself. A felo de se therefore is he that deliberately puts an end to his own existence, or commits any unlawful malicious act, the consequence of which is his own death: as if, attempting to kill another, he runs upon his antagonist's sword; or, shooting at another, the gun bursts and kills himself. The party must be of years of discretion, and in his senses, else it is no crime. But this excuse ought not to be strained to that length, to which our coroners juries are apt to carry it, viz, that the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal non compos, as well as the self-murderer. * * *

> "But now the question follows, what punishment can human laws inflict on one who has withdrawn himself from their reach? They can act only on what he has left behind him, his reputation and his fortune: on the former, by an ignominious burial in the highway, with a stake driven through his body; on the latter, by a forfeiture of all his goods and chattels to the king: hoping that his care for either his own reputation, or the welfare of his family, would be some motive to restrain him from so desperate and wicked an act. . . . And, though it must be owned that the letter of the law herein borders a little upon severity, yet it is some alleviation that the power of mitigation is left in the breast of the sovereign, who upon this (as on all other occasions) is reminded by the oath of his office to execute judgment in mercy."[20]

The above quote is given at such length, not to evoke a frisson of horror at the way suicides were once treated, but simply to show that the exemplary punishment meted out to suicides—a punishment that could be mitigated by the sovereign—reflects the English (and at that time American) Common Law's abhorrence for suicide, which is not tempered by the fact that mercy could and did mitigate the punishment. What is important is the expression of a clear disapproval of suicide, which disapproval was in no sense diminished by the feeling, which was to grow, that punishing the successful suicide was both futile and cruel. However, this judgment has absolutely nothing to do with the notion of a fundamental right to physician-assisted suicide. Nor can it be argued that Blackstone's *Commentaries* were unrepresentative, being either reactionary—*i.e.*, a statement of the law as it was, but is no longer—or revolutionary—*i.e.*, a statement not of the law as it was, but as Blackstone wished it to be in the future. The *Commentaries* were a single-handed massive compilation that became authoritative for all judges and lawyers of what the Common Law was at the time of the writing: a kind of Restatement of the Common Law at the moment that the American Republic was founded.

20 WILLIAM BLACKSTONE 4 COMMENTARIES *189-90.

The American Experience

The English philosopher whose work stands most behind the Framers of the Declaration of Independence was, as is well known, John Locke.[21] Locke's *Second Treatise of Government* is most relevant here; scholars of the Revolution generally have agreed that it is this work which influenced Jefferson the most in drafting the Declaration of Independence.[22] When Jefferson wrote that "all men . . . are endowed

21 "[T]he great virtuosi of the American Enlightenment—Franklin, Adams, Jefferson—cited the classical Enlightenment texts . . . . In pamphlet after pamphlet the American writers cited Locke on natural rights and on the social and governmental contract." BERNARD BAILYN, THE IDEOLOGICAL ORIGINS OF THE AMERICAN REVOLUTION 27 (1967).

22 "That the central argument of the Declaration is based mainly upon John Locke's *Second Treatise* is indisputable." Forrest Macdonald, *Novus Ordo Seclorum* ix (1985).

by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness," we look to Locke as his source, "but Jefferson, as is well known, departed from Locke's trinity of 'life, liberty, and estate' and substituted 'the pursuit of happiness' for the third of these."[23]

To understand what Jefferson meant by inalienable rights to life and liberty, we have to look to the *Second Treatise*, where Locke, in his chapter on "The State of Nature," observes:

> "though this be a State of Liberty, yet it is not a State of License, though Man in that State have an uncontrollable Liberty, to dispose of his Person or Possessions, yet he has not liberty to destroy himself, or so much as any Creature in his Possession, but where some nobler use, than its bare Preservation calls for it. . . . Every one as he is bound to preserve himself, and not to quit his Station wilfully; so by the like reason when his own Preservation comes not in competition, ought he, as much as he can, to preserve the rest of Mankind, and may not unless it be to do Justice on an Offender, take away, or impair the life, or what tends to the Preservation of the Life, the Liberty, Health, Limb or Goods of another."[24]

Later in the *Second Treatise*, Locke returns to the theme that "a Man" does not have "the Power of his own Life":

> "This Freedom from Absolute, Arbitrary Power, is so necessary to, and closely joyned with a Man's Preservation, that he cannot part with it, but by what forfeits his Preservation and Life together. For a Man, not having the Power of his own Life, cannot, by Compact, or his own Consent, enslave himself to any one, nor put himself under the Absolute, Arbitrary Power of another, to take away his Life, when he pleases. No body can give

[23] *Id.*

[24] John Locke, *Two Treatises on Government*, Second Treatise, at 270-71.

> more Power than he has himself; and he that cannot take away his own Life, cannot give another Power over it."[25]

Locke's firmly repeated anti-suicide theme expressed in another way—one more familiar to Americans—is that these rights are "inalienable"—for Jefferson's formulation is an expression of the demands of Lockean natural rights. Yet none of this obviously relevant historical data—not Locke, not Jefferson, not the Declaration of Independence, and certainly not the function of the Constitution in preserving and protecting these very rights—merits even passing mention in the majority's relentless historical review. Nor does Lincoln, whose comment on *Scott* v. *Sandford*, *supra*, illustrates what happens when the Judiciary ignore the meaning of the Declaration of Independence:

> "In those days, our Declaration of Independence was held sacred by all, and thought to include all; but now . . . it is assailed, and sneered at, and construed, and hawked at, and torn, till, if its framers could rise from their graves, they could not at all recognize it . . . .
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> "Chief Justice Taney, in his opinion in the Dred Scott case, [did] obvious violence to the plain unmistakable language of the Declaration. . . . [T]he authors of that notable instrument . . . defined with tolerable distinctness, in what respects they did consider all men created equal—equal in 'certain inalienable rights, among which are life, liberty, and the pursuit of happiness.' This they said, and this they meant. . . .
>
> "And now I appeal to all . . . are you really willing that the Declaration shall be thus frittered away?—thus left no more at most, than an interesting memorial of the

[25] *Id.*, Chapter IV, Sec. 23, at 284.

> dead past? thus shorn of its vitality, and practical value. . . ?"[26]

Lincoln's understanding of the respect owed to principles of the Declaration led him to issue the Emancipation Proclamation despite the objections of many in his Cabinet. History has already judged whether Lincoln or Taney was right.

The Several States

Turning briefly to American law, the majority opinion tells us that

> "by 1798 six of the 13 original colonies had abolished all penalties for suicide either by statute or state constitution. There is no evidence that any court ever imposed punishment for suicide or attempted suicide under common law in post-revolutionary America."

79 F.3d at 809. The question is what we are expected to make of this information, particularly in the context of the relevant historical data which the majority ignores or twists to support its preconceived outcome. Again, if the majority had chosen to utilize Marzen on this point, the outcome would be different:

> "The principal piece of evidence concerning the rationale of the colonists for their abolition of forfeiture is in a 1796 treatise by Zephaniah Swift, later Chief Justice of Connecticut, that clearly establishes that rationale.

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[26] Speech on the Dred Scott decision, Springfield, Illinois, June 26, 1857, in ABRAHAM LINCOLN, 1 SPEECHES AND WRITINGS 396-400 (Don E. Fehrenbacher, ed., Library of America 1989). Contrast Lincoln's insistence on equality in the inalienable right to life with the majority opinion's remark that "even though the protection of life is one of the state's most important functions, the state's interest is dramatically diminished if the person it seeks to protect is terminally ill or permanently comatose and has expressed a wish that he be permitted to die. . . . When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling." 79 F.3d at 820.

> 'There can be no act more contemptible, than to attempt to punish an offender for a crime, by exercising a mean act of revenge upon lifeless clay, that is insensible of the punishment. There can be no greater cruelty, than the inflicting of punishment, as the forfeiture of goods, which must fall solely on the innocent offspring of the offender. This odious practice has been attempted to be justified upon the principle, that such forfeiture will tend to deter mankind from the commission of such crimes, from a regard for their families. But it is evident that where a person is so destitute of affection for his family, and regardless of the pleasures of life, as to wish to put an end to his existence, that he will not be deterred by a consideration of their future subsistence. Indeed, this crime is so abhorrent to the feelings of mankind, and that strong love of life which is implanted in the human heart, that it cannot be so frequently committed, as to become dangerous to society. There can of course be no necessity of any punishment. This principle has been adopted in this state, and no instances have happened of a forfeiture of estate, and none lately of an ignominious burial.'
>
> "Swift makes clear that the traditional penalties were abolished not because suicide itself was viewed as a lesser evil or as a human right, but because the penalties punished the innocent family of the suicide, without in any way reaching the real perpetrator of the act."[27]

The majority opinion tells us that "[b]y the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the 37 states is it clear that there were statutes prohibiting assisted suicide." 79 F.3d at ___. While the majority denigrates in a footnote what it

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[27] Marzen at 68-69, citing Zephaniah Swift, *A System of Laws of the State of Connecticut* 305 (n.p. 1795). Clearly, footnote 494 to Milsom is mistaken.

characterizes as Marzen's "extrapolating from incomplete historical evidence and drawing inferences from states' treatment of suicide and later historical evidence" to hypothesize a contrary conclusion, *id.* at 809, reference to Marzen presents a very different picture:

> "When the fourteenth amendment was ratified in 1868, nine of the thirty-seven states had statutes that prohibited assisting suicide. Of these, all but one state's legislature voted to ratify; Mississippi did not vote. In addition, Massachusetts, which voted to ratify, had case law to the same effect, and since South Carolina (which voted to ratify) had a statute condemning suicide as a felony while retaining the common law of crimes, it may be presumed that that state also criminalized assisting suicide. Under the same principles of imputation employed with regard to the ninth amendment, ten additional states (Alabama, Connecticut, Georgia, Kentucky, Maryland, Michigan, North Carolina, Pennsylvania, Tennessee, and Virginia) can be held to have prohibited assisting suicide under the common law of crimes. Of these, all but two voted to ratify; the legislatures of Kentucky and Maryland voted against the fourteenth amendment.
>
> "Of four states that ratified the fourteenth amendment (Nevada, New Hampshire, Rhode Island and West Virginia), and one that voted against ratification (Delaware), it can be said with confidence that although these states recognized the common law of crimes, there is insufficient evidence, apart from that, to establish their positions on attempting suicide or assisting suicide. Vermont, which voted to ratify, and California, which did not vote, applied the common law, but it is unclear whether they included the common law of crimes.
>
> "Illinois, Indiana, Iowa, Louisiana, Maine, Nebraska, and Texas, which voted to ratify, and Ohio, which voted against ratification, had no prohibition on assisting suicide. The status of New Jersey is unclear. Of the ten existing territories, Washington prohibited assisting suicide by statute; Colorado, the District of Columbia, Idaho and Wyoming recognized the common law of crimes, but, again, there is insufficient evidence to establish their position on assisting suicide; Arizona and Utah applied the common law, but it is unclear whether they included the common law of crimes; New Mexico and North Dakota had no prohibition on assisting suicide; and the status of Montana is unclear.
>
> "In short, twenty-one of the thirty-seven states, and eighteen of the thirty ratifying states prohibited assisting suicide. Only eight of the states, and seven of the ratifying states, definitely did not."[28]

We leave it for this Court to judge whether the majority's derogatory characterization of Marzen's scholarship withstands analysis.

In the majority's entire historical survey, only one State law case is actually discussed, and that in the last paragraph:

> "The New Jersey Supreme Court declared in 1901 that since suicide was not punishable it should not be considered a crime. '[A]ll will admit that in some cases it is ethically defensible,' the court said, as when a woman kills herself to escape being raped or 'when a man curtails weeks or months of agony of an incurable disease"

79 F.3d at 809-10, citing *Campbell* v. *Supreme Conclave Improved Order Heptasophs*, 66 N.J.L. 274, 49 A. 550 (1901). However, once again the majority opinion's actual source, reveals a quite different slant to the same information. Thus, Marzen introduces his discussion of *Campbell* as follows:

> "Perhaps a better candidate for [the] title of 'Aberrant Jurisdiction' (though the jurisdiction quickly repudiated it), would be New Jersey. In a 1901 insurance case,

---

[28] Marzen at 76-76.

> *Campbell v. Supreme Conclave Improved Order Heptasophs*, nine of the seventeen members of the state's highest court joined in an opinion by Justice Gilbert Collins stating that since suicide was not punished with forfeiture, it was not a crime. * * *
>
> "It is, however, the only pre-1980 case we have found that articulates such a view. It is isolated not only in contrast to cases in other jurisdictions, but within New Jersey as well. Two years later, an inferior appellate court took the extraordinary step not only of criticizing the Justice Collins' opinion but also rendering a holding directly contrary to its language, which it characterized as dictum."[29]

Burke Balch, one of the co-authors of the Marzen article, noted recently, as had the original article, that "[i]ndeed, in 1922, New Jersey's highest court wrote, 'So strong is this concern of the state [in the preservation of the life of each of its citizens] that it does not even permit a man to take his own life."[30]

CONCLUSION

In addition to all of the other grounds urged by Petitioners and other *Amici*, we respectfully submit that the inaccurate and at times even dishonest use of history in the majority decision requires that this Court reverse the judgment below and dismiss the underlying complaint on the basis of the reasoning of the dissent below.

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[29] Marzen at 84, citing *State* v. *Carney*, 69 N.J.L. 478, 55 A. 44 (Sup. Ct. 1903).

[30] Burke Balch, *Court Suicide Decision Distorts American History*, NAT'L RIGHT TO LIFE NEWS, May 7, 1996, at 22. The case is *State* v. *Ehlers*, 98 N.J.L. 236, 241, 119 A.15, 17 (1922).

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In The
Supreme Court of the United States
October Term, 1996

STATE OF WASHINGTON, ET AL.,
Petitioners-Appellants,

v.

HAROLD GLUCKSBERG, ET AL.,
Respondents-Appellees.

On Appeal From The United States Court Of Appeals For The Ninth Circuit

BRIEF FOR THE NATIONAL SPINAL CORD INJURY ASSOCIATION, INC., AS *AMICUS CURIAE* SUPPORTING APPELLANTS

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No. 96-110

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1996

STATE OF WASHINGTON, ET AL.,
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v.

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BRIEF FOR THE NATIONAL SPINAL CORD INJURY ASSOCIATION, INC., AS *AMICUS CURIAE* SUPPORTING APPELLANTS

INTEREST OF THE NATIONAL SPINAL CORD INJURY ASSOCIATION, INC.

The National Spinal Cord Injury Association, Inc. ("NSCIA") is the largest civilian organization in the United States dedicated to improving the quality of life of persons disabled by spinal cord injury. The NSCIA was founded by the Paralyzed Veterans of America in 1948 and, until its relocation to the Washington, D.C. area in July, 1996, was headquartered near the medical and rehabilitative communities in Boston, Massachusetts.

Its members are among the more than 250,000 Americans paralyzed as a result of injury and disease to the spinal cord.

Spinal cord injury is regarded by many, particularly those who have only collateral experience with persons so afflicted, as constituting one of the most debilitating and tragic of human conditions. Cases of extreme spinal cord injury have been cited as illustrating the type of impairment (especially during the early days after an injury) which may warrant or support a desire in the disabled individuals involved to hasten their death.

The NSCIA has a unique knowledge of, and experience with, all types of spinal cord injury ("SCI") and with the profound quality of life issues which confront both newly disabled individuals and persons with long histories of spinal injury. The NSCIA has established a network of over 30 local chapters and support groups nationwide for the spinal-injured, their families, and the professionals involved with their care. The NSCIA also operates a national toll-free referral hot line which fields thousands of inquires each year from newly injured individuals and others, promotes nationwide peer counseling groups, and maintains a 60,000-item library -- the largest and most current resource center in the world with information about spinal cord injury.

The NSCIA's formal mission is "to enable people with SCI to make choices and take actions to achieve their highest level of independence and personal fulfillment." The organization has a unique, real world insight and perspective on some of the core assumptions expressed by the United States Court of Appeals for the Ninth Circuit in this "assisted suicide" case. To the best of its knowledge, the NSCIA has never in its 48-year history participated as an *amicus curiae* in any case before this Court. On this occasion, however, owing to its mission statement and the responsibility it feels to its past, present, and future clients and members, the NSCIA is compelled to submit this brief to address certain profound misconceptions contained in the lower court's

decision, which violates American tradition and jurisprudence and which establishes a dangerous and socially undesirable precedent -- as a matter of constitutional law, ethics and moral responsibility.

SUMMARY OF THE ARGUMENT.

In purporting to fashion a new substantive due process "right," the Ninth Circuit misconstrued this Court's decision in Roe v. Wade and its progeny. (pp. 4-5). The lower court failed to address the paramount effect of Natural Law in the circumstances (pp. 5-8) and failed to recognize that the unalienable Right to Life, which has not been implicated in the prior abortion decisions of this Court, predominates and invalidates the necessarily qualified liberty interest in assisted suicide which the lower court has created. (pp. 8-12). A right-to-die is not "implicit in the concept of ordered liberty," (pp. 12-15), nor was such purported "right" presaged or mandated by this Court's decision in Cruzan v. Director, Missouri Dept. of Health. (pp. 15-17).

The Ninth Circuit gave inadequate weight to the State's interest in protecting the disabled from being indirectly and unduly encouraged to participate in assisted suicides. (pp. 17-20). Sanctioning the practice of assisted suicides would represent an especially undesirable social policy for the spinal cord injured in this country. If a right to assisted suicide is recognized by this Court, there is a grave and irreversible risk, inter alia, that temporarily despondent, spinal-injured persons may err in rendering literal life-and-death decisions. (pp. 20-26).

ARGUMENT.

I. The Ninth Circuit Erred In Creating A New Constitutional "Liberty Right" To Decide The Time And Manner Of One's Death And In Elevating This Liberty Right Over The Unalienable Right To Life.

A. Introduction: Nature of Ninth Circuit's Fundamental Error.

In Compassion in Dying v. State of Washington, 79 F.3d 790, 793-794 (9th Cir. 1996), the Circuit Court of Appeals for the Ninth Circuit ("Ninth Circuit") concluded that "there is a constitutionally-protected liberty interest in determining the time and manner of one's own death... [and] that insofar as the Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to hasten their own deaths, it violates the Due Process Clause of the Fourteenth Amendment." The Ninth Circuit erred.

The threshold premise underlying the lower court's analysis, namely that there are "compelling similarities between right-to-die cases and abortion cases," Compassion in Dying v. State of Washington, supra at 800, is fundamentally flawed. The assumption that "both types of cases raise issues of life and death," id. at 800-801, misapprehends this Court's decision in Roe v. Wade, 410 U.S. 113 (1973) and its progeny. In defining the privacy right of a woman to terminate a pregnancy, this Court has never characterized the countervailing interest in protecting the aborted fetus as representing an interest in preserving "life." This Court has never ruled that the woman's privacy rights predominate a right of "life," as such, in the fetus. To the contrary, this Court has always emphasized in the abortion context that the existence of the fetus (regardless of the trimester involved) represents merely a "potential life." The characterization of the fetus' interest as being that of a "life interest," as necessarily implied in the Ninth Circuit's decision, represents a matter of religious and

moral values — upon which neither society, the medical world, nor this Court has ever developed a definitive consensus.[1]

Contrary to the Ninth Circuit's conclusion that its creation of a "right-to-die" may, in effect, be considered "identical to the approach used by the Supreme Court in the abortion cases," Compassion in Dying v. State of Washington, supra at 801, the lower court's decision violates Roe, American tradition and culture, and fundamental tenets of both Natural Law and constitutional law.

B. Deference Should Be Paid to the Supreme Authority of Natural Law Whenever Purporting to Recognize New Substantive Due Process Rights.

Natural Law is as old as Aristotle, and as classical as Cicero. See Aristotle, Rhetoric, Book 1, Chapter 13 (1373 b 4) (d. *Circa* 323 B.C.); Aristotle, Nicomachean Ethics, Book 5, Chapter 7 (1134 b. 18); Cicero, De Re Publica, III, xxii, 33 fl. 1st century B.C. It is not old-fashioned, out-of-date, or irrelevant in the context of assisted suicide, although the Ninth Circuit apparently chose to disregard this principal source of constitutional insight in its entirety. Natural Law has a special significance, value and function in establishing a safety net of rights for those segments of contemporary society which are most vulnerable to abuse, error or indifference in the application of the law — the poor, minorities, and disabled -- i.e., those who are least likely to influence the

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[1] This court ruled in Roe that, "[i]f ... personhood is established, the appellant's case [i.e., the demand for abortion], of course, collapses, for the fetus' right to life would then be guaranteed specifically by the [Fourteenth] Amendment." Roe v. Wade, 410 U.S. at 156-157.

political process and least able to pursue justice through the courts.

Since the inception of the United States, this nation has defined its essential identity and ultimate being by reference to Natural Law. The supreme authority of Natural Law was first ordained as a self-evident and timeless tenet in our Declaration of Independence. See *Declaration of Independence*, pars. 1-2. As Justice Jackson wrote in American Communications Association v. Douds, 339 U.S. 382, 439 (1949), the people "who led the struggle forcibly to overthrow lawfully constituted British authority found moral support by asserting a natural law under which their revolution was justified, and they broadly proclaimed these beliefs in the document basic to our freedom."

The supreme authority of Natural Law represents a fundamental premise underlying the very existence of the Constitution. See *Declaration of Independence*, pars. 1-2. See generally J. Locke, *The Second Treatise of Government* (J. Gough rev ed. 1976) (3d ed.) (1698). Its primacy and importance should be recognized and reaffirmed on any occasion in which the courts purport to create and define wholly new constitutional rights, as purportedly involved here. In quoting ancient treatises in Geer v. Connecticut, 161 U.S. 519 (1896), this Court noted that:

> "There are things which we acquire the dominion of, as by the law of nature, which the light of natural reason causes every man to see, and others we acquire by the civil law; that is to say, by methods which belong to the government ... (quoting Dig. Bk., tit. 1, *De Adquir. Ref. Dom.*).
>
> "The civil law, it is said, cannot be contrary to the natural law. This is true as regards those things which the natural law commands or which it forbids; but the civil law can restrict that which the natural law only permits. The greater part of all civil laws are nothing but restrictions on those things which the natural law would otherwise permit."

Id. at 523-524, quoting Pothier, *Traite du Droit de Propriete*, Nos. 27-28.

In noting that there is no calculus for determining which of the first eight Amendments are incorporated into the Fourteenth Amendment, for example, Justice Frankfurter in Adamson v. People of State of California, 322 U.S. 46, 65 (1947) (concurring opinion) wrote:

> "[i]n the history of thought 'natural law' has a much longer and much better founded meaning and justification than such subjective selection of the first eight Amendments for incorporation into the Fourteenth."

See also Faretta v. California, 422 U.S. 806, 831 n.39 (1975), quoting Thomas Paine on *Bill of Rights*, 1977, reprinted in 1 Schwartz 316 ("[T]he civil right of pleading by proxy, that is, by a council, is an appendage to the natural right [of self-representation]....") (parenthetical in original). See further Archibald Cox, *The Role of the Supreme Court in American Government* (New York: Oxford University Press, 1976) at 31-32 ("Belief in natural rights and natural law were deeply ingrained in the eighteenth-century American mind .... The conviction that there were such natural rights made it easy to express them in a Constitution, and then to accept the notion that a duly enacted statute in conflict with natural rights was not a binding law .... This early belief in the supremacy of natural law and its survival into our own time, albeit with different intellectual trappings and under other names, helped to secure acceptance of the legitimacy of judicial supremacy on matters of constitutional interpretation").

In its decision in this case, the Ninth Circuit acknowledged that "[t]his is the first right-to-die case that this

court or any other federal court of appeals has ever decided." Compassion in Dying v. State of Washington, 79 F.3d at 794. In purporting to review historic and legal attitudes toward life and suicide, however, the lower court did not even take into account the existence or effect of Natural Law in addressing this issue for the first time.[2]

C. The Unalienable Right to Life Predominates and Invalidates the Qualified Liberty Interest Identified by the Ninth Circuit.

Under Natural Law and contemporary constitutional principles (until the Ninth Circuit's decision in this case), the Right to Life has been regarded as unalienable. The Declaration of Independence memorializes as a "self-evident" truth that all persons "are endowed by their Creator with certain unalienable Rights [and] that among these are Life...." *Declaration of Independence*, par. 2. The Right to Life necessarily supersedes

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[2] In discussing historical attitudes toward suicide, the Ninth Circuit instead cited, inter alia, Greek and Roman "literature, mythology, and practice." See id. at 806-808. Such references are not especially illuminating. If the attitudes commonly reflected in such sources alone were a guide to defining contemporary constitutional law, then bestiality and incest could perhaps be regarded as protected liberty rights under the Fourteenth Amendment. Likewise, the reference to the Roper Report and public opinion surveys in the Ninth Circuit's opinion should form no basis for this Court's ultimate analysis of the constitutional principles involved. If public opinion were to drive constitutional analysis, protected conduct such as flag burning and inter-racial marriage (indeed many of the privileges conferred by the Bill of Rights) would never have been recognized as liberty interests.

any rights or privileges conferred by civil authorities and any qualified liberty interests conferred by the courts. The tenet in our legal tradition that "[l]ife is the immediate gift of God, a right inherent by nature in every individual," 1 Blackstone, *Commentaries* 129-130, is not an inscrutably religious or moral concept and should be given consideration and deference in this Court's analysis of any purported constitutional "right-to-die."

Because it is unalienable, the Right to Life predominates the Ninth Circuit's newly identified liberty interest in choosing the time and manner of one's death. See Arkes, *"Once More Unto the Breach: The Right to Die -- Again,"* 8 Issues in L. & Med. 317, 319 (1992) ("unalienable rights" are those which we are "not competent to alienate or waive, even for ourselves, because the goodness or badness of these rights was grounded in principle, quite independent of our will"). By the Ninth Circuit's own analysis, such a liberty interest is derivative of the right of privacy and must thus be considered dependent upon Natural Law. See Griswold v. Connecticut, 381 U.S. 479, 510 n.1 (1965) (Black, J., dissenting) ("'A right of privacy in matters purely private is .... derived from natural law'") (citation omitted).

The strongest supporters of liberty interests in general have recognized that such rights are nevertheless qualified in nature and are not unalienable like the Right to Life. Perhaps the premier advocate of individual rights, John Stuart Mill, recognized that personal autonomy represents a qualified right which may be regulated by the State. See J.S. Mill, *Utilitarianism* and *On Liberty* at 141 (M. Warnock Fontana Library ed. 1962) (State may prevent individual from voluntarily alienating his or her rights). See also Bowers v. Hardwick, 478 U.S. 186, 205 (1986) (Blackman, J., dissenting) ("[T]he 'ability independently to define one's identity that is central to any concept of liberty' cannot truly be exercised in a vacuum ...."), quoting Roberts v. United States Jaycees, 468 U.S. 609, 619 (1984).

The individual's rights to liberty and autonomy in American law are necessarily qualified and limited "by clear and unquestionable authority of law." Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891). Historically, the States may regulate, and have regulated, a person's course of conduct in order to prevent that individual from harming himself or herself. There are numerous areas of American law where the States have undertaken to protect individuals against their own intentions or imprudence. See Buck v. Bell, 274 U.S. 200 (1927) (sterilization); Zucht v. King, 260 U.S. 174 (1922) (vaccination); Jacobson v. Massachusetts, 197 U.S. 11, 26 (1905) (upholding compulsory vaccination law and rejecting purported "inherent right of every free man to care of his own body").

The "state may regulate its internal affairs for the protection and promotion of general health, safety, morals and welfare of its citizens even where it proves inconvenient or offensive to a particular individual." Note, "Compulsory Medical Treatment: The State's Interest Re-evaluated," 51 Minn. L. Rev. 293, 297 (1966). See National Treasury Employees Union v. Von Raab, 489 U.S. 656 (1989) (drug testing); Schmerber v. California, 384 U.S. 757 (1966) (upholding compulsory blood-test of accused). See also People v. Carmichael, 56 Misc. 388, 288 N.Y.S.2d 931 (Genesse County Ct. 1968) (motorcyclist protective helmets); DeAryan v. Butler, 119 Cal.App.2d 674, 260 P.2d 98 (1953), cert. denied, 347 U.S. 1012 (1954) (flouridation of water); State v. Massey, 229 N.C. 734, 51 S.E.2d 179 (1949), appeal dismissed, 336 U.S. 942 (1949) (snake handling as expression of religious belief); Davis v. State, 118 Ohio St. 25, 160 N.E.473 (1928) (palm reading and fortune telling). A plethora of pure food and drug laws, licensure schemes, and regulations controlling noxious substances exists which interfere with individual freedom of choice and prevent people from injuring themselves. These laws prevent individuals from subjecting themselves to risks which the government considers inadvisable and effectively preclude persons from individual self-determination and from selecting their own risks. See United States v. Walsh, 331 U.S.

432 (1947); Purity Extract & Tonic Co. v. Lynch, 226 U.S. 192 (1912).[3]

The abortion cases upon which the Ninth Circuit heavily relied in fashioning its "right-to-die" present no exception to the consistent principle in constitutional law that the Right to Life always and necessarily supersedes any qualified, prospective liberty interest conferred by the Fourteenth Amendment. In Roe v. Wade and its progeny, a woman's right to terminate her pregnancy has been balanced against the mere "potential life" interest of the fetus (regardless of the trimester period involved or regardless of viability), not a definitive life interest as would inherently be involved when assessing a liberty interest purportedly possessed by an adult — whether terminally ill or otherwise.[4] Accordingly,

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[3] In the context of medical treatment, a physician's professional judgment, as a general matter, is legally restricted or precluded in many situations. Laws governing narcotics, experimental drugs, and compulsory reporting demonstrate that professional judgment is not always of paramount consideration. See Rosenberg, *Compulsory Disclosure Statutes*, 280 N. Eng. J. Med. 1287 (1969). See generally Baron, *"Medical Paternalism and the Rule of Law,"* 4 Amer. J. of L. and Med. 337, 340 ("A decision to end the life of a terminally ill patient is no more a mere 'medical question' to be decided by doctors than a decision to declare war is a mere 'military question' to be decided by generals").

[4] In this context, the Ninth Circuit's evocative analogy to both "abortions and assisted-suicides [as] flourish[ing] in back alleys, in small street-side clinics, and in the privacy of the bedroom," Compassion in Dying v. State

(continued...)

when measured against the unalienable Right to Life, the Ninth Circuit's qualified liberty interest in choosing the time and manner of one's death is conceptually inferior and, resultantly, not cognizable or viable.

D. A Right to Die Is Not "Implicit in the Concept of Ordered Liberty."

The newly created right of "choosing the time and manner of one's death," Compassion in Dying v. State of Washington, 79 F.3d at 798, does not, of itself, have an experiential reality, other than for individuals who either contemplate the affirmative taking of their lives or actively harbor such a desire. No readers of these words, apart from those having suicidal ideation, either know or have an opportunity to know the time or manner in which they are to die. Accordingly, from the outset, any such "right" is

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[4](...continued)
of Washington, 79 F.3d at 801, appears to be strained. In the words of the lower court, the "tragic consequence" if a woman was required to terminate her pregnancy without the assistance of a medical professional is that she would risk serious personal injury to herself or even perhaps death in extreme cases of neglect by the non-professional. Such "tragic consequence" seems less compelling and realistic in the context of a terminally ill patient, where death itself is the desired end. The real tragedy in such circumstances is not that a **professional** is not able to facilitate the death, but rather that the patient has not been sufficiently comforted by attendant health care practitioners or supported by family and friends in the first instance, such that the uncertain fate of death holds more promise to that individual rather than his or her continued existence.

substantially more abstract than the types of concrete interests previously recognized by this Court as being afforded Fourteenth Amendment protection. See Loving v. Virginia, 388 U.S. 1 (1967) (marriage); Skinner v. Oklahoma, 316 U.S. 535 (1942) (procreation); Prince v. Massachusetts, 321 U.S. 158 (1944) (family relationships); Pierce v. Society of Sisters, 268 U.S. 510, 534-535 (1925) (child rearing and education); Griswold v. Connecticut, 381 U.S. 479 (1965) (intercourse for purposes other than procreation); Eisenstadt v. Baird, 405 U.S. 438 (1972) (decision whether to bear child); and Roe v. Wade, 410 U.S. 113 (1973) (abortion).

In general, this Court has deferred extending constitutional protection to purported due process rights unless such interests are considered "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." Palko v. Connecticut, 302 U.S. 319, 325-326 (1937). See also Moore v. East Cleveland, 431 U.S. 494 (1977) (characterizing liberty interests as being those which are "deeply rooted in this Nation's history and tradition"). This Court has cautioned that "'[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for 'the doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.'" Reno v. Flores, 507 U.S. 292, 302 (1993). See also Bowers v. Hardwick, 478 U.S. at 190 ("[T]here should be ... great resistance to expand the substantive reach of [the due process clauses of the Fifth and Fourteenth Amendments], particularly if it requires redefining the category of rights deemed fundamental").

As the Ninth Circuit itself appropriately noted in its decision, the creation of a new liberty interest should reflect "the conscience, traditions, and fundamental tenets of our nation." Compassion in Dying v. State of Washington, 79 F.3d at 802. The purported "right-to-die" created by the lower court in this case, however, does not reflect such tradition nor does it represent an interest "implicit in the concept of ordered liberty." See Palko v.

Connecticut, 302 U.S. at 325-326. To the contrary, suicide and assisted suicide have been historically viewed as crimes under our heritage and law. Suicide was prohibited under the English common law probably as early as the 13th century. See Compassion in Dying v. State of Washington, supra at 808. See also 2 H. de Bracton (c. 1250) reprinted in *On the Laws and Customs of England* 423 (S. Thorn trans., 1968). John Locke specifically opposed suicide as being against Natural Law and the principle of self-preservation. See Thomas J. Marzen, et al., *Suicide: A Constitutional Right*, 24 Duq. L. Rev. 1, 42 (1985). By 1868, 21 of the then 37 states in this country prohibited assisted suicide. Id. at 25. Today, a substantial majority of the States continue to outlaw assisted suicide. Julia Pugliese, Note, *Don't Ask — Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L. J. 1291, 1295 (1993). See also Compassion in Dying v. State of Washington, 79 F.3d at 847 (Beezer, J., dissenting) (noting that currently 44 States plus District of Columbia prohibit assisted suicide).

The fact that courts and juries may have historically treated prosecutions of suicides with lenity and have viewed persons who attempted suicide as not being of sound mind indicates perhaps tolerance and compassion (as well as a practical understanding of the limited deterrent effect of criminal penalties for suicide), but not recognition that such conduct is commendable, "implicit in the concept of ordered liberty," Palko v. Connecticut, 302 U.S. at 325-326, or that such purported "right" should be safeguarded from State regulation except under the most exacting standards of strict scrutiny constitutional analysis. The lack of consensus on such a right is exemplified by the procedural history of this case alone and the fact that the 3-judge panel originally hearing it decided not to recognize a constitutional "right-to-die." Compassion in Dying v. State of Washington, supra at 798.

The Ninth Circuit's discussion of the individual circumstances of an AIDS patient identified by the fictitious name

of Smith, see id. at 814, evokes a powerful image for which only the most callous or heartless could not feel compassion and sympathy. A timeless "law school adage," although a cliche, is nonetheless true: bad cases make for bad law. It should not be an acceptable practice for this Court to reason alone from specific examples like the ones described by the Ninth Circuit, no matter how sympathetic, in attempting to identify and define for the entire Nation the parameters of constitutional law and the existence of fundamental liberty interests.

E. A Right-to-Die Was Not Presaged or Mandated by this Court's Ruling in *Cruzan*.

Aside from misapprehending the decisions in Roe v. Wade and its progeny, the Ninth Circuit also misconstrued this Court's decision in Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990). Contrary to the Ninth Circuit's characterization of that decision, Cruzan involved the refusal of unwanted medical treatment and was not a "right-to-die case...." Compassion in Dying v. State of Washington, supra at 799. More importantly, this Court's decision in Cruzan did not "necessarily recognize[] a liberty interest in hastening one's own death," as the Ninth Circuit has concluded. Compassion in Dying v. State of Washington, supra at 816. Nothing in the text of the Justices' opinions in that case, nor subsequent interpretations of this decision by courts (other than the Ninth Circuit in this particular case) have suggested that Cruzan stands for the proposition that the Constitution requires or supports recognition of a "right-to-die." To the contrary, the majority in Cruzan concluded that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." See Cruzan v. Director, Missouri Dept. of Health, 497 U.S. at 282. See also id. at 300 (Scalia, J., concurring) ("[T]he power of the State to prohibit suicide is unquestionable").

Likewise, the Ninth Circuit erred in equating an individual's decision to act affirmatively and directly to hasten his or her death with the decision to refrain from receiving intrusive or extraordinary medical treatment. The interests implicated when deciding to terminate unwanted medical treatment are not necessarily equivalent to the interests involved when terminating an unwanted life. Although the Ninth Circuit declined to recognize so, there is a profound difference in the conduct of physicians "prescribing medication ... for the purpose of enabling a patient to end his life," with a patient's "act of refusing or terminating unwanted medical treatment." Compassion in Dying v. State of Washington, 79 F.3d at 802.

In this case, the Ninth Circuit should not have rejected so casually the philosophical and legal distinction between acts of commission and omission and between active conduct which promotes death versus passive conduct which merely permits the natural process of dying to occur. Compassion in Dying v. State of Washington, 79 F.3d at 821. Physician-life-ending conduct, which was not approved by Cruzan, but which would now be authorized according to the Ninth Circuit's decision, would be profoundly different in kind from the type of conduct addressed by this Court in Cruzan. "Assisted suicide" would require doctors to play an active role and be a causal agent of their own patients' deaths in violation of the Hippocratic Oath.[5] "Assisted suicide"

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[5] The Ninth Circuit's characterization of the Hippocratic Oath as "hav[ing] no greater import in deciding the constitutionality of physician assisted-suicide than it did in determining whether women had a constitutional right to have an abortion," Compassion in Dying v. State of Washington, supra at 829, suffers from the same infirmity discussed earlier in this brief, namely, the lower court's apparent failure to appreciate that a "life" interest in the fetus has never been acknowledged as being

(continued...)

would cause patients to die not from the natural symptoms of their underlying disease, but rather from death-inducing "medication" administered from their treating physicians' own hands. See Cruzan v. Director, Missouri Dept. of Health, 497 U.S. at 300 (Scalia, J., concurring) (commenting that suicide "consists of an affirmative act to end one's life; refusing treatment is not an affirmative act 'causing' death, but merely a passive acceptance of the natural process of dying").

Accordingly, given the Ninth Circuit's mistaken interpretations of this Court's prior decisions in Roe v. Wade, 410 U.S. at 113 and Cruzan v. Director, Missouri Dept. Of Health, 497 U.S. at 261 and that court's erroneous analysis of those factors which are essential in order to create new substantive due process rights (especially where such a purported interest implicates, and intrudes upon, the unalienable Right to Life), the decision recognizing a constitutional "right-to-die" should be reversed, and such purported "right" should be declared invalid.

II. Alternatively, If This Court Were To Recognize A Constitutional "Right-to-Die," It Should Ensure That Such Right Would Be Rigidly Qualified And Never Applied Against The Interests Of The Disabled.

A. Sanctioning Assisted Suicide Will Place Undue Pressure on the Disabled.

If this Court were to recognize a constitutional "right-to-die," despite the many and profound obstacles which should properly preclude it from so doing, the *amicus* NSCIA

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[5](...continued)
implicated in this Court's abortion decisions, in contrast to the "life" interest which would undeniably and intrinsically be involved in an adult person's decision to terminate his or her existence.

takes special exception to the inadequate weight given by the Ninth Circuit to the State's interest in preserving the sanctity of life and in protecting the disabled from being indirectly and unduly encouraged to participate in assisted suicides.

The Report of the Council on Ethical and Judicial Affairs, see Joint Appendix B at 133, specifically cites as realistic the "slippery slope" concern that "[p]ermitting assisted suicide opens the door to policies that carry far greater risks." Id. at 140. According to the Report,

> "if assisted suicide is permitted, then there is a strong argument for allowing euthanasia. It would be arbitrary to permit patients who have the physical ability to take a pill to end their lives, but not let similarly suffering patients die if they require the lethal drug to be administered by another person. Once euthanasia is permitted, however, there is a serious risk of involuntary deaths."

Id. at 140. See also Compassion in Dying v. State of Washington, 79 F.3d at 853 (Beezer, J., dissenting) ("The poor, the elderly, the disabled and minorities are all at risk from undue pressure to commit physician-assisted suicide, either through direct pressure or through inadequate treatment of their pain and suffering").

In its decision, the Ninth Circuit specifically commented upon "slippery slope" concerns and the related fear "advanced by some representatives of the physically impaired ... that certain physical disabilities will erroneously be deemed to make life 'valueless.'" Compassion in Dying v. State of Washington, supra at 825.[6] The lower court purported to "recognize the legitimacy of

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[6] In its decision, the Ninth Circuit never defined precisely what it meant by the term "terminally ill adults,"

(continued...)

these concerns," id. at 825, but then rather cavalierly dismissed them with the chilling observation that:

> "seriously impaired individuals will, along with non-impaired individuals, be the beneficiaries of the liberty interest asserted here — and that if they are not afforded the option to control their own fate, they like many others will be compelled, against their will, to endure unusual and protracted suffering."

Id. at 825.

The Ninth Circuit's reasoning here completely misses the concerns of disability organizations such as the *amicus* NSCIA. The NSCIA and its members are not interested in securing the "benefit" of the right-to-die espoused by the Ninth Circuit. Id. at 825. Instead, the NSCIA is committed to improving its clients'

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[6](...continued) although it did comment in its discussion of mootness that "the most common classification of terminally ill persons limits that group to individuals who are expected to die within six months." Id. at 796, n.4. Although the lower court appeared to restrict its recognition of a constitutional "right-to-die" to such "terminally ill" persons, there appears to be no logical reason to suppose that such a right would ultimately be restricted to this group alone, if this Court were to agree with the Ninth Circuit and affirm the creation of an assisted suicide "right." Indeed, if a right-to-die were recognized as having constitutional dimension, the Equal Protection Clause could be invoked in subsequent cases to invalidate the requirements of "terminal illness" and "mental competency" described in the Ninth Circuit's decision as impermissibly treating similarly situated groups of patients differently.

quality of life. In this regard, the lower court's priorities are misplaced. If an appreciable segment of the population is not being properly cared for, such that some of its members request assistance at suicide, the more compassionate solution is not to confer a constitutional right to permit such conduct (and thus eliminate the problem along with the patient), but rather to redouble the efforts of health care professionals to better respond to the needs of the patients under their care, to treat pain and other discomfort more aggressively through stronger medications or otherwise, to better alleviate physical and emotional suffering, and to better counsel persons regarding pain management techniques. See generally Report of the Council on Ethical and Judicial Affairs, Joint Appendix B at 141-142.

B. <u>The Risk of Error in the Life-Death Decision Process for Spinal-Injured Persons Is Grave</u>.

Of further and even greater concern to the *amicus* NSCIA is the grave risk of irreversible error in the literal life-and-death decisions the Ninth Circuit's decision would encourage. That court's rationalization that "should an error actually occur[,] it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most desirable," <u>Compassion in Dying v. State of Washington</u>, 79 F.3d at 824, misapprehends and trivializes the concerns of the NSCIA for those disabled by spinal injuries, most especially the newly injured.

No doubt many tragic and sympathetic images of human suffering among the terminally ill may be invoked in support of the position that this Court should sanction the practice of assisted suicide. Perhaps equally (if not more) compelling, however, are the experiences of those individuals who may only temporarily regard themselves as in effect being terminally ill, who may for a short period of time subjectively believe that their lives are no longer worth living, and whose lifestyles have been so

substantially affected that their family members and health care providers would objectively support their desire to terminate their life, if such an option were given constitutional recognition.

To appreciate the inherent risk, it may be useful for this Court to learn and weigh the most current statistical data regarding the incidence of traumatic spinal cord injury in the United States. The following information was compiled primarily by researchers with the National Spinal Cord Injury Statistical Center at the University of Alabama using data from the regional SCI Centers funded by NIDRR. Such information is reported in Factsheet 2: *"Spinal Cord Injury Statistical Information,"* the most recent edition of which was published by the NSCIA in August, 1995.

Every year, approximately 8,000 to 10,000 new spinal cord injuries are sustained by Americans, mostly teenage males, primarily as a result of vehicle accidents, acts of violence, sports-related injuries and falls. <u>Id.</u> The highest per capita rate of injury occurs between the ages of 16-30 years. <u>Id.</u> The average age at injury is 33.4 years, the median age at injury is 26 years, and the most frequent age at injury is 19 years. <u>Id.</u> Motor vehicle accidents are the leading cause of spinal cord injury (44%), followed by acts of violence (24%), falls (22%), sports (8%), and other (2%). <u>Id.</u> Approximately two-thirds of sports injuries are from diving. <u>Id.</u>

The primary symptom of spinal cord injury is paralysis which takes two forms: 1) paraplegia, which is paralysis affecting the legs and lower parts of the body, and 2) quadriplegia, which is paralysis affecting the level below the neck and chest area and which involves both the arms and the legs. <u>Id.</u> Paralysis is often accompanied by a partial or complete loss of sensation and various bodily functions, as well as a host of other secondary medical problems, such as: demineralization of bone, reduction in pulmonary function, dysfunction of the kidney, bladder and bowels, sexual dysfunction, muscle spasms, skin sores, and chronic pain. <u>Id.</u> Individuals with SCI encounter other problems

beyond these physical symptoms, such as: coping with the stigma of being disabled, barriers to employment opportunities, difficulties expressing sexuality, and other social and personal issues which can be a major part of living with a spinal cord injury. Id.

Since 1988, 45% of all spinal cord injuries have been classified as "complete," meaning that the injuries have resulted in a total loss of sensation and function below the injury level; 55% of spinal injuries are classified as "incomplete," meaning that the individual involved experienced only a partial loss of sensation and function below the injury level. Id. Slightly more than one-half of all injuries result in quadriplegia. Id. However, the proportions of quadriplegics increase markedly after age 45, comprising two-third of all injuries after the age of 60 and 87% of all injuries after the age of 75. Id. Most people with neurologically complete lesions above C-3, who survive their injury, become dependent upon mechanical respirators to breathe. Id. Overall, 85% of SCI patients who survive the first 24 hours after their injury are still alive 10 years later. Id.

As stated in this brief when discussing the "Interest of the Amicus," supra, p. 2, few injuries are considered as debilitating as a spinal cord injury. Such injuries most frequently occur abruptly during one's relative youth as a result of a sudden accident, giving the affected individual and his or her family essentially no time to prepare emotionally for what may both initially and ultimately require a drastic alteration in the injured person's lifestyle. Factsheet 2, supra. Obviously, it is not uncommon for the affected individual to become seriously depressed and to question whether his or her life, given the nature and extent of the restrictions which may be imposed by the disability, is worth living. Not infrequently, the newly spinal-injured in particular may harbor thoughts about the quality of their existence and may speculate whether their lives, with little hope for a recovery, continue to have value. The process of emotional adjustment, of course, varies greatly among the individuals involved. Commonly, such

process may progress through distinct stages somewhat comparable to the emotional adjustment which individuals may experience as a result of the death of a loved one.

It is in this context, that the Ninth Circuit's response to the express concern that "certain physical disabilities will erroneously be deemed to make life 'valueless'," Compassion in Dying v. State of Washington, 79 F.3d at 825, seems incomplete and hollow. The lower court's rationalization that

> "[o]rganizations representing the physically impaired are sufficiently active politically and sufficiently vigilant that they would soon put a halt to any effort to employ assisted suicide in a manner that affected their clients unfairly,"

id. at 825, appears to be unduly optimistic and uninformed. The *amicus* NSCIA, as just one example, although constituting the largest civilian organization in its field, is (like most disability organizations) a not-for-profit corporation with limited financial resources. Owing to its network of local chapters and support groups and its peer assistance counseling programs, the NSCIA is perhaps in a slightly better position than most national disability organizations to assure that certain newly injured individuals are receiving sufficient care and encouragement, are retaining hope, and are being empowered to confront the obstacles their injuries may present to them. Nonetheless, given the thousands of newly injured persons across the country each year and the limited financial resources available to the organization, it is more likely and more realistic to expect that the NSCIA would be able only to **respond** to specific inquiries from its members and clients, rather than proactively discover individual cases in which severe despondency and/or tragic errors in its clientele's expectations may occur. Until suicidal ideation becomes more socially and culturally acceptable and common, moreover (a "value" which is antithetical to the NSCIA's mission and a judgment which it hopes this society never establishes as an ideal), it is likely that most persons contemplating suicide would not readily or publicly

disclose their intentions, making it that much more difficult for the NSCIA to identify and respond to an individual's need. Over time, assisted suicides in this context could be portrayed and encouraged as being an heroic sacrifice to permit a reallocation of limited medical resources to others and to alleviate a "burden" on the time and finances of the disabled person's family. Those opting to live could be viewed as "selfish" and as constituting a drain on society and their loved ones.[7]

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[7] The Dutch experience with euthanasia, cited in the Council on Ethical and Judicial Affairs in the Joint Appendix at 141, demonstrates the risks of sanctioning physician-assisted suicide. In the Netherlands, there are strict criteria for the use of euthanasia which are similar to the criteria proposed for assisted suicide in the United States. In a leading Netherland's study, see id., however, researchers found that, in about 28% of the cases of euthanasia or physician-assisted suicide, the strict criteria were not fulfilled, suggesting that some patients' lives were ended prematurely or involuntarily. In the 1991 Remmelink Report, moreover, more than one-half of the Dutch physicians considered it appropriate to initiate the subject of euthanasia with their patients. See Rothman, *"Doctored Death,"* The Nation at 26 (November 18, 1996), reviewing Herbert Hendin, M.D., *Seduced by Death: Doctors, Patients, and the Dutch Cure* (Norton: 1996). These physicians apparently justified this practice as not constituting a form of coercion, but rather as merely enabling their patients to consider an option that they otherwise might not have raised. Id. In such circumstances, particularly where the individual involved has recently suffered a sudden and debilitating injury, it requires little imagination to see how the physician's initiative might

(continued...)

The recognition of a "right-to-die" would undermine the mission of the NSCIA and ultimately the value society places on the lives of all of its members. To adopt the analysis of the Ninth Circuit would be to decide that our society no longer values its members insofar as they are persons with intrinsic dignity — that is, with inherent value independent of what they can do and contribute — but only insofar as they are useful, or so long as their lives have sufficient "quality." However, each individual's life is a gift bestowed and protected by the human community and by the ultimate forces that make up the cycle of birth and death. As the NSCIA knows only too well from its experiences with the spinal-injured, in life there may be suffering, as there is joy. But, suffering does not render a life meaningless or worthless. "Suffering people need the support of others; suffering people should not be encouraged to commit suicide by their community, or that community ceases to be a community." Dyck, *"An Alternative to the Ethic of Euthanasia,"* reprinted in Ethics and Medicine at 533 (Cambridge: MIT Press 1977). Persons do not, and should not, live purely unto themselves.[8]

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[7](...continued)
be interpreted as a warning ("no one would want to go through what I know is in store for you") or abandonment ("you are no longer worth caring for") or dismissal ("your life is not worth living"). Id.

[8] "No man is an island, intire of its selfe; every man is a piece of the Continent, a part of the maine ... and man's death diminishes me, because I am involved in mankind."

John Donne
Devotions Upon Emergent Occasions

Allowing a patient, guardian, or physician to determine that a "terminally ill" person's life is, in effect, "worthless" necessarily involves a subjective judgment about that person's quality of life and creates dangerous precedent. The same judgment could be applied with equal force to circumstances much different than those involved in Compassion in Dying v. State of Washington. See Siegler and Weisbard, 145 Arch. Intern. Med. 129, 130 (1985) ("We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive'").

> "If it becomes entrenched practice to kill by omission certain sorts of persons whose condition is very poor and whose lives are judged by others no longer to be worth living, then this method of killing surely will be extended to many other persons. Most of the cases that have attracted attention thus far has involved the very severely brain damaged — those who are permanently unconscious, severely damaged by strokes, in advanced stages of dementia due to Alzheimer's or another disease, and so on. But the various sort of damages, defect, debility, and handicap that burden human lives occur in myriad degrees, so that there are always more and less severe cases differing from one another only by degree. Unfortunately, it is not difficult to image a future America in which human life may itself be judged excessively burdensome for all persons who cannot care for themselves and have no one willing and able to care for them."

May, et al., 3 Issues in L. & Med. 203, 207 (1987).

CONCLUSION.

The judgment of the Ninth Circuit Court of Appeals should be reversed, and the purported "right-to-die" recognized by that court should be declared invalid.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, et al.
Petitioners,

vs.

HAROLD GLUCKSBERG, M.D., COMPASSION IN DYING, INC., JANE ROE, JOHN DOE, JAMES POE
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE SOUTHERN CENTER FOR LAW AND ETHICS AS AMICUS CURIAE IN SUPPORT OF THE STATE OF WASHINGTON, ET AL.

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No. 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, et al.
Petitioners,

vs.

HAROLD GLUCKSBERG, M.D., COMPASSION IN DYING, INC., JANE ROE, JOHN DOE, JAMES POE
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE SOUTHERN CENTER FOR LAW AND ETHICS AS AMICUS CURIAE IN SUPPORT OF THE STATE OF WASHINGTON, ET AL.

INTEREST OF AMICUS CURIAE

The Southern Center for Law and Ethics is a non-profit, publicly funded, tax-exempt corporation founded in 1985 and based in Birmingham, Alabama. Paramount to the Center's purpose is to develop an understanding of the relationship between law and religion. The Center's activities include interaction and instruction with interested law students, medical students, lawyers,

physicians, and members of the academic community, publication of articles and a journal of theology and law, and providing legal counsel and filing *amicus curiae* briefs on a variety of public issues related to the Center's purposes.

The Center is particularly concerned that contemporary public policy not be based upon distorted and inaccurate interpretations of Christian history or theology. The Ninth Circuit *en banc* opinion, authored by Judge Reinhardt, which is being reviewed in this case, includes a flagrantly inaccurate and illogical discussion of suicide and the early church. The purpose of this brief is to provide the Court with a balanced appraisal of the subject of suicide and the early church, so that this Court does not repeat those errors. In order to assist the Court, numerous quotations from the Church Fathers on this topic are included.[1] Counsel for all parties have consented to the filing of this brief.

SUMMARY OF ARGUMENT

Judge Reinhardt's discussion of the place of suicide in Early Christianity[2] contains three assumptions, which upon examination are false and illogical:

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[1]We wish to credit Darrel W. Amundsen who assisted in the research and preparation of this brief, which draws upon his earlier works, "Suicide and Early Christian Values," in *Suicide and Euthanasia: Historical and Contemporary Themes*, B. A. Brody, ed. (Dordrecht: Kluwer, 1989), pp. 77-153; idem, *Medicine, Society, and Faith in the Ancient and Medieval Worlds* (Baltimore: Johns Hopkins University Press, 1996), pp. 70-126; idem, "Did Early Christians 'Lust After Death'? A New Wrinkle in the Doctor-Assisted Suicide Debate," *Christian Research Journal* (Spring, 1996):11-21; and idem, "The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide," in *Physician-Assisted Suicide: Ethical Positions, Medical Practices, and Public-Policy Options*, R. Weir, ed. (Bloomington: Indiana University Press [forthcoming, 1997]).

I. Judge Reinhardt's first assumption

A. Assumption: Because the church promoted such a bleak view of life and such a glorious view of heaven, suicide became an increasingly strong temptation for early Christians.[3]

B. Response: There is no evidence of any Christian, during the period under consideration, committing suicide, in the ordinary sense of the word, in order to accelerate his entering heaven. Further, suicide was clearly condemned by the early church, but in terms that indicated that suicide was not a serious temptation or problem for members of the church.

II. Judge Reinhardt's second assumption

A. Assumption: The type of suicide in question is martyrdom.[4]

B. Response: Martyrdom, prior to the legalization of Christianity, was a special situation involving state persecution of a specific religion. Martyrdom was not indicative of a general desire for death, but only for death at the hands of another for the sake of Christ, in imitation

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[2]*Compassion in Dying v. Washington*, 79 F.3d 790, 808 (9th cir. en banc 1996).

[3]79 F.3d at 808. Judge Reinhardt states:

> "The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven. 'In other words, the more powerfully the Church instilled in believers the idea that this world was a vale of tears and sin and temptation, where they waited uneasily until death released them into eternal glory, the more irresistible the temptation to suicide became." *Id.* (footnote number omitted).

[4]*See* 79 F.3d at 808.

of Christ's death. It was that which was "tempting." Death as a release from physical or mental suffering was not at issue. Hence, Christianity did not teach that one had a general right to control the end of one's own life, but to the contrary, that one was not permitted to do so. Denominating the acceptance of martyrdom for one's religious faith as a form of "suicide" is hopelessly confusing, and obscures rather than clarifies the issues related to physician-assisted suicide. Judge Reinhardt's thinking and terminology are so muddled that he is willing to consider Christians executed for their faith as "suicides," yet later in the same opinion he denies that those who *request* that their physicians kill them are "suicides."

Rather than promoting suicide as a solution for illness and physical pain, the early church emphasized the ethical obligations to care for the sick, and to patiently endure illness and suffering, that had been lacking in Greek and Roman ethics.

III. Judge Reinhardt's third assumption

A. Assumption: The martyrdoms, predominantly of Donatists (a schismatic sect that arose nearly simultaneously with the legalization of Christianity), so threatened to deplete the ranks of Christendom that Augustine condemned suicide in general as a damnable sin. Prior to Augustine, the Church had failed clearly to condemn suicide.[5]

B. Response: There are several logical absurdities here:

1. If the church were to have adopted an anti-suicide stance because of utilitarian concerns with the ranks of Christendom being depleted by martyrdom, it surely

[5] *See* 79 F.3d at 808.

would have done so earlier, when Christians were a small minority, rather than during Augustine's lifetime when the church was being flooded with "converts" whose attraction to Christianity were the social and political advantages legally available to Christians.

2. If Augustine's concern was that the ranks of Christendom were being depleted by martyrdom and if these martyrs were Donatists, i.e., members of a schismatic sect, then allowing the practice to continue would have reduced the ranks of the very people who were the Catholic Church's greatest religious competition at that time.

3. Historically, the assumption that Augustine created a reversal of church teaching is false, as demonstrated both by the extensive quotation of pre-Augustinian sources cited herein, as well as by the fact that the Eastern, Greek-speaking Church, upon which Augustine's Latin writings had little influence, nonetheless clearly taught an anti-suicide position.

ARGUMENT

I. Suicide was clearly condemned by the pre-Augustinian church, but in terms that indicated that suicide was not a serious temptation for Christians

Suicide is rarely mentioned in the New Testament. The only suicide recorded there is that of Judas (hardly a model of Christian virtue), and his self-destruction is reported without comment (Mt. 25:5; Acts 1:18). Suicide arises incidentally on some other occasions. When Jesus said, "Where I go, you cannot come," this made the Jews ask, "Will he kill himself?" (Jn. 8:21-22). Moreover, one suicide is prevented in the New Testament. Paul and Silas had been freed from prison in Philippi by an earthquake. When the jailer was about to kill himself in despair, Paul intervened by offering him salvation, which he joyfully accepted (Acts 16:25-34). In some cases of demon posses-

sion self-destructive tendencies are manifested, e.g., in Mark's accounts of the Gerasene demoniac (Mk. 5:5) and of the mute boy (Mk. 9:14-29). In the latter, the boy's father told Jesus that the demon had "often thrown him into the fire or water to kill him" (Mk. 9:22). The New Testament contains no other reference to potential or realized suicide.

Although suicide is a topic that excited little comment by church fathers before Augustine, one encounters passing references. An anonymous author of the *Shepherd of Hermas*, a work that was composed in stages between 90 and 150, contends that one who is harassed by distress (*incommoda*) should be assisted, for "many bring death on themselves by reason of such calamities when they cannot bear them. Whoever therefore knows the distress of such a man, and does not rescue him, incurs great sin and becomes guilty of his blood."[6] This suggests that the author held the suicide of one who resorted to such a deed because of distress as so serious a matter that whoever could have helped but failed to do so not only was guilty of a serious sin but of the suicide's blood.

Justin Martyr (ca. 100-165) envisages a pagan exclaiming, "All of you, go kill yourselves and thus go immediately to God and save us the trouble." Justin responds, "If . . . we should kill ourselves we would be the cause, as far as it is up to us, why no one would be born and be instructed in the divine doctrines, or even why the human race might cease to exist; if we do act thus, we ourselves will be opposing the will of God."[7] This occurs in juxtaposition to Justin's assertion of Christians' willingness to die for their faith. This passage, although it is an unequivocal condemnation of suicide for Christians, is only an explanation provided to pagans of why Christians

[6]"Similitude" 10.4.3, in *Shepherd of Hermas*, in *AF* 2:305.

[7]Justin Martyr, *2 Apology* 4, in *FC* 6: 123.

do not kill themselves. Justin appears not to have felt it incumbent upon himself to provide any moral explanation or scriptural defense of his position. Although his argument is sufficiently Platonic to be familiar to educated pagans, it contains ingredients that even Platonists would find unpalatable: Christians must not kill themselves because God wants them in the world and humanity needs them, for if there were no Christians not only would there be no one to instruct pagans in the truth, but also since God sustains the world for his people's sake, the human race would cease to exist if all Christians were removed from the face of the earth.

A similar message is contained in the late second-century, anonymous *Epistle to Diognetus*:

> The soul is locked up in the body, yet is the very thing that holds the body together; so, too, Christians are shut up in the world as in a prison, yet are the very ones that hold the world together. Immortal, the soul is lodged in a mortal tenement; so, too, Christians, though residing as strangers among corruptible things, look forward to the incorruptibility that awaits them in heaven. The soul, when stinting itself in food and drink, is the better for it; so, too, Christians, when penalized, increase daily more and more. Such is the important post to which God has assigned them, and it is not lawful for them to desert it.[8]

In the so-called Clementine *Homilies*, probably redacted to their present form in the mid-fourth century but based on a late second/early third-century original, the apostle Peter encounters a pagan woman who is considering killing herself because of various afflictions. He

[8]*Epistle to Diognetus*, in J. Quasten, *Patrology*, vol. 1, *The Beginnings of Patristic Literature* (1950; reprint, Westminster: Christian Classics, 1983), p. 251.

says to her, "Do you suppose, O woman, that those who destroy themselves are freed from punishment? Are not the souls of those who thus die punished with a worse punishment in Hades for their suicide?"[9] It is uncertain whether the conviction that suicide will compound one's future punishment was in the original or added by a fourth-century redactor.

Clement of Alexandria (ca.155-ca.220) viewed as a *praeparatio evangelica* those features of Greek philosophy that he regarded as consonant with divine revelation. He especially admired the Stoic concept of *apatheia* (insensibility to suffering). But in his thought the Stoic concept is so thoroughly informed by scriptural principles that the *apatheia* that he lauds as a Christian ideal could never reasonably lead to, much less justify, suicide:

> [By] going away to the Lord [the Christian] does not withdraw himself from life. For that is not permitted to him. But he has withdrawn his soul from the passions. For that is granted to him. And on the other hand he lives, having put to death his lusts, and no longer makes use of the body, but allows it the use of necessaries, that he may not give cause for dissolution [of the body].[10]

Clement's was a Stoicism that had been Christianized to such a degree that suicide was permitted neither in the active sense (i.e., "withdrawing from life," a popular Stoic expression for suicide) nor in the passive sense (i.e., allowing the dissolution of the body by failing to provide it with necessities).

Tertullian (ca.160-ca.220), commenting on Christ's having commanded his followers "to give to the one who asks," says that "if you take His command generally, you

[9] *Clementine Homilies* 12.14, in *ANF* 8:295.

[10] Clement, *Stromateis* 6.9, in ANF 2:497.

would be giving not only wine to a man with a fever, but also poison or a sword to one who wanted to die."[11] It was regarded as exceedingly harmful for the febrile to consume wine. Tertullian includes in the same category assisting one to commit suicide. A Christian simply will not supply the means if asked. In another work Tertullian classifies as demented or insane (possibly demon possessed) anyone who "cuts his own throat."[12]

There is no suggestion in the sources thus far surveyed that for contemporary Christians suicide either posed a theoretical, much less a practical, problem or was an attraction to them. Such will continue to be the case through the end of the patristic era.

Lactantius (ca.240-320), appointed professor of oratory in Nicomedia by the emperor Diocletian, and later converted to Christianity, resigned his position when the "Great Persecution" began in 303. He wrote his major apologetic work, the *Divine Institutes*, to persuade educated pagans of the truth of Christianity and to edify and encourage Christians who were troubled by philosophical attacks against their faith. Discussing various pagan philosophers, he says that many of them, "because they suspected that the soul is immortal, laid violent hand upon themselves, as though they were about to depart to heaven." He then asserts that

> nothing can be more wicked than this. For if a homicide is guilty because he is a destroyer of man, he who puts himself to death is under the same guilt, because he puts to death a man. Yea, that crime may be considered to be greater, the punishment of which belongs to God alone. For

[11] Tertullian, *Flight in Time of Persecution* 13.2, in *FC* 40:304.

[12] Tertullian, *Apology* 23.3, in *FC* 10:71-72. See also ibid., 46.14, 50.4-11; *To the Martyrs* 4.9; and Timothy D. Barnes, *Tertullian: A Historical and Literary Study* (Oxford: Clarendon, 1971), pp. 218-19.

> as we did not come into this life of our own accord; so, on the other hand, we can only withdraw from this habitation of the body which has been appointed for us to keep, by the command of Him who placed us in this body that we may inhabit it, until He orders us to depart from it. . . . All these philosophers, therefore, were homicides.[13]

Some years later Lactantius yielded to requests to write an abridgement of the *Divine Institutes*. In his *Epitome* he asks whether we should approve those

> who, that they might be said to have despised death, died by their own hands? Zeno, Empedocles, Chrysippus, Cleanthes, Democritus, and Cato, imitating these, did not know that he who put himself to death is guilty of murder, according to the divine right and law. For it was God who placed us in this abode of flesh: it was He who gave us the temporary habitation of the body, that we should inhabit it as long as He pleased. Therefore it is to be considered impious, to wish to depart from it without the command of God. Therefore violence must not be applied to nature. He knows how to destroy His own work. And if any one shall apply impious hands to that work, and shall tear asunder the bonds of the divine workmanship, he endeavors to flee from God, whose sentence no one will be able to escape, whether alive or dead. Therefore they are accursed and impious, whom I have mentioned above, who even taught what are the befitting reasons for voluntary death; so that it was not enough of guilt that they were self-murderers, unless they instructed others also to this wickedness.[14]

[13]Lactantius, *Divine Institutes* 3.18, in *ANF* 7:88-89.
[14]Lactantius, *Epitome* 39, in *ANF* 7:237.

In his *Divine Institutes* Lactantius condemns suicides as worse than homicides on the Christianized Platonic grounds that suicides desert the place to which God has appointed them. In his *Epitome* he adds the offenses of attempting to flee from God by committing violence against nature, and encouraging others to do likewise. In his second work his tone is even more vitriolic and outraged than in the first: suicides are not only homicides but are impious as well.

Lactantius' contemporary, Eusebius (ca.265-339), writes

> It is worthy of note that, as the records show, in the reign of Gaius . . . Pilate himself, the governor of our Saviour's day, was involved in such calamities that he was forced to become his own executioner and to punish himself with his own hand: divine justice, it seems, was not slow to overtake him. The facts are recorded by those Greeks who have chronicled the Olympiads together with the events occurring in each.[15]

Eusebius clearly regarded Pilate's suicide from despair as God's just penalty, a condemnation for his sin of sentencing Jesus to death by crucifixion.

Eusebius quotes from the anti-Montanist work of Bishop Apolinarius of Hierapolis, written during the reign of Marcus Aurelius, the following account of the deaths of Montanus (the founder, in the late second century, of the charismatic and prophetic sect that bears his name) and one of his prophetesses, Maximilla:

> It is thought that both of these were driven out of their minds by a spirit, and hanged themselves, at different times; and on the occasion of the death of each, it was said on all sides that

[15]Eusebius, *History of the Church* 2.7.1, p. 81 in Williamson's translation.

> this was how they died, putting an end to themselves just like the traitor Judas. . . . But we must not imagine that without seeing them we know the truth about such things, my friend: it may have been in this way, it may have been in some other way, that death came to Montanus . . . and [his] female associate.[16]

Neither Eusebius nor his source would vouch for the accuracy of this account. Including it, however, they suggest death by suicide as appropriate for two whom they regarded as notorious heretics.

Basil of Caesarea (ca.329-379), in one of his "canonical letters" writes that a woman who has an abortion is guilty not only of the murder of the fetus but also of "an attempt against her own life, because usually the women die in such attempts."[17] It is obvious that Basil was speaking for and to a community that regarded even an attempt on one's own life as sinful.

John Chrysostom (349-407), writing on Galatians 1:4 (Jesus "gave himself for our sins to rescue us from the present evil world, according to the will of our God and Father"), castigates those dualistic heretics who viewed the material world as evil. He takes the words "evil world" to mean

> evil actions, and a depraved moral principle. . . . Christ came not to put us to death and deliver us from the present life in that sense, but to leave us in the world, and prepare us for a worthy participation of our heavenly abode. Wherefore He saith to the Father, "And these are in the world, and I come to Thee; I pray not that Thou shouldest take them from the world, but that Thou shouldest keep them from the evil,"

[16]Ibid., 5.16.13 and 15, p. 220.
[17]*Letters* 188.2, in *FC* 2:12-13.

> i.e., from sin. Further, those who will not allow this, but insist that the present life is evil, should not blame those who destroy themselves; for as he who withdraws himself from evil is not blamed, but deemed worthy of a crown, so he who by a violent death, by hanging or otherwise, puts an end to his life, ought not to be condemned. Whereas God punishes such men more than murderers, and we all regard them with horror, and justly; for if it is base to destroy others, much more is it to destroy one's self.[18]

Chrysostom thus asserts that dualistic heresy encourages suicide. True Christians — "we all" would be the orthodox community — according to Chrysostom justly regard suicide with horror. Such a statement would be preposterous if there had been any sympathy within the orthodox community with suicide to escape "the present evil world."

Augustine's erstwhile mentor, Ambrose (ca.339-97), says of Paul's statement "For to me, to live is Christ and to die is gain" (Phil. 1:21):

> For Christ is our king; therefore we cannot abandon and disregard His royal command. How many men the emperor of this earth orders to live abroad in the splendor of office or perform some function! Do they abandon their posts without the emperor's consent? Yet what a greater thing it is to please the divine than the human! Thus for the saint "to live is Christ and to die is gain." He does not flee the servitude of life like a slave, and yet like a wise man he does embrace the gain of death.[19]

[18]John Chrysostom, *Commentary on Galatians* 1:4, in *NPNF-1*, 13:5.
[19]Ambrose, *Death as a Good* 3.7, in *FC* 65:73-74.

Once again we see a Christianized form of the Platonic argument against suicide. Elsewhere Ambrose writes to his sister Marcellina,

> You make a good suggestion that I should touch upon what we ought to think of the merits of those who have cast themselves down from a height, or have drowned themselves in a river, lest they should fall in the hands of persecutors, seeing that holy Scripture forbids a Christian to lay hands on himself.[20]

It is very significant that Ambrose simply states that Scripture forbids suicide and does not seem to feel compelled to defend that contention. He speaks with the same degree of confidence that his audience will agree as does Chrysostom when he says, "we all regard suicides with horror, and justly."

In a letter to the lady Paula, who was distraught over the death of her daughter Blaesilla, Jerome (ca.345-ca.419) asks,

> Have you no fear, then lest the Savior may say to you: "Are you angry, Paula, that your daughter has become my daughter? Are you vexed at my decree, and do you, with rebellious tears, grudge me the possession of Blaesilla? You ought to know what my purpose is both for you and for yours. You deny yourself food, not to fast but to gratify your grief, and such abstinence is displeasing to me. Such fasts are my enemies. I receive no soul which forsakes the body against my will. A foolish philosophy may boast of martyrs of this kind; it may boast of a Zeno, a Cleombrotus, or a Cato. My spirit rests only upon him 'that is poor and of a contrite

[20]Ambrose, *Concerning Virgins* 3.7.32, in *NPNF-2*, 10:386.

> spirit and that trembleth at my word' [Is. 66:2]."[21]

Jerome qualifies this apparently unlimited condemnation of suicide elsewhere: "It is not ours to lay hold of death, but we freely accept it when it is inflicted by others. Hence, even in persecutions it is not right for us to die by our own hands, except when chastity is threatened, but to submit our necks to the one who threatens."[22]

Both Ambrose and Jerome make one exception to their otherwise inclusive condemnation of suicide: if it is done for the preservation of chastity. Only a small minority of patristic sources prior to Augustine mention this category of suicide; those that do, approve it.[23] Augustine's rejection of the probity of suicide to preserve chastity led him to engage in a thorough analysis of suicide in book one of the *City of God*. The first installment of this massive work was published in 414, four years after the Goths' sack of Rome.

II. The early church emphasized an obligation of care for the sick and the patient endurance of suffering, rather than suicide, as the appropriate response to illness

Christianity not only condemned pagan immorality but it also introduced moral obligations that were altogether foreign to the Greek and Roman ethos. One of

[21]Jerome, *Letters* 39.3, in *NPNF-2*, 6:51.

[22]Jerome, *Commentarius in Ionam prophetam* 1.6, in *Patrologia cursus completus, Series Latina*, Jacques Paul Migne, ed. (Paris: J. P. Migne, 1844-65) 1.12:390-91 (my translation).

[23]See also Eusebius, *History of the Church* 8.12.3-4, 8.14.14 and 17, and Chrysostom, *Homilia encomastica*, in *Patrologia cursus completus, Series Graeco-Latina*, Jacques Paul Migne, ed. (Paris: J. P. Migne, 1857-66), 49:579-84.

these was a duty to care — not a duty to cure,[24] but a duty to care — an obligation to extend practical compassion to the destitute, the widow, the orphan, and the sick. This introduced a truly radical transformation in attitudes toward the sick. Henry Sigerist has observed that Christianity inaugurated

> the most revolutionary and decisive change in the attitude of society toward the sick. Christianity came into the world . . . as the joyful Gospel of the Redeemer and of Redemption. It addressed itself to the disinherited, to the sick and the afflicted. . . . It became the duty of the Christian to attend to the sick and poor of the community. . . . The social position of the sick man thus became fundamentally different from what it had been before. He assumed a preferential position which has been his ever since.[25]

Although early Christians lived in a secular milieu in which suicide by the ill was frequently practiced and its probity seldom questioned,[26] not only is there no discussion of the issue in patristic literature but there is also not a single example of Christians committing suicide, asking others' assistance in doing so, or requesting others to kill them directly, in order to escape from the grinding tedium of chronic, or the severe suffering of termi-

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[24]See the compelling study by Gary B. Ferngren, "Early Christianity as a Religion of Healing," *Bulletin of the History of Medicine* 66 (1992): 1-15.

[25]Henry Sigerist, *Civilization and Disease* (Chicago: University of Chicago Press, 1943), pp. 69-70. Sigerist was an avowed Marxist and no apologist for Christianity. See *Henry E. Sigerist: Autobiographical Writings*, selected and translated by Nora Sigerist Beeson (Montreal: McGill University Press, 1966), p. 110.

[26]See Danielle Gourevitch, "Suicide among the Sick in Classical Antiquity," *Bulletin of the History of Medicine* 43 (1969): 501-18, and van Hooff, *From Autothanasia to Suicide*, especially pp. 122-26.

nal, illness. The only ethical issues raised by illness in patristic literature are 1) the tendency of some Christians to seek medical care without first pondering the spiritual dimensions of their suffering; 2) their having recourse to pagan or magical healing alternatives; and 3) their occasionally frantic struggles to find and cling to any even meager hope of recovery. Not only is suicide by the ill never raised as an ethical issue in the literature of early Christianity but also there is not a scintilla of evidence that the preferential position that Christianity gave to the sick included an expedited "final exit." The goodness and sovereignty of God and the patient endurance of affliction are so regularly and consistently stressed in patristic theology that it is not surprising that patristic texts are void of any reference to suicide by the ill.

III. Judge Reinhardt's illogical and inaccurate statements about suicide and the early church are rooted in an academic ideology that deliberately blurs the distinction between being martyred for one's beliefs and committing suicide to avoid suffering

In his treatment of the early history of suicide, Judge Reinhardt relied primarily upon a popularized account written by poet, literary critic, and playwright, Alfred Alvarez.[27] The historical and theological presuppositions and conclusions of Alvarez are consistent with those of some philosophers, sociologists, anthropologists, psychologists, and popular authors who have written, even incidentally, on suicide in early Christianity during the last several decades. Alvarez's understanding of suicide in

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[27]Judge Reinhardt's quotations are from Alvarez's "The Background," in *Suicide: The Philosophical Issues*, M. P. Battin and D. J. May, eds. (New York: St. Martin's, 1980), pp. 7-32, which is chapter one of Alvarez's very influential book, *The Savage God: A Study of Suicide* (New York: Random House, 1970).

early Christianity suggests not only an ignorance of early Christian theology and history but also the conceptual influence of Émile Durkheim, the father of academic sociology in France.[28]

Durkheim's definition of suicide is very well known to students of the social sciences: "All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result."[29] Durkheim was determined to avoid the question of motivation or even whether the individual actually desired to die. It is suicide if one believes that one's actions or passivity will eventuate in one's own death. Hence, he classifies the death of Christian martyrs as (altruistic) suicide, since they

> without killing themselves, voluntarily allowed their own slaughter. . . . Though they did not kill themselves, they sought death with all their power and behaved so as to make it inevitable. To be suicide, the act from which death must necessarily result need only have been performed by the victim with full knowledge of the facts.[30]

According to Durkheim, dying for one's beliefs is suicide. Since those who commit suicide are, in Durkheim's construct, victims of pathological social phenomena, martyrs are victims not of the people who kill them but of their own religious group's demand for excessive integration, control, and regimentation.

Arthur J. Droge and James D. Tabor begin and end their recent work, *A Noble Death: Suicide and Martyrdom*

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[28]Émile Durkheim, *Suicide: A Study in Sociology*, J. A. Spaulding and G. Simpson, trans. (Glencoe, Ill.: The Free Press, 1951).

[29]Ibid., p. 44.

[30]Ibid., p. 227; cf. p. 67.

among Christians and Jews in Antiquity,[31] by referring to the current debate regarding physician-assisted suicide. Unfortunately, Droge and Tabor adopt terminology which they concede to be quite similar to Durkheim's. Rejecting for their purposes the word suicide as "a recent innovation and pejorative term," they substitute the designation "voluntary death," which they define as

> the act resulting from an individual's intentional decision to die, either by his own agency, by another's, or by contriving the circumstances in which death is the known, ineluctable result.

Droge and Tabor's determination to label such a diverse variety of motives and actions "voluntary death" entangles them in contradictions and absurdities. For example, when dealing with the Old Testament, Droge and Tabor comment on Elijah's request that God take his life (1 Kings 19:4-5): "Though no act of self-destruction is involved, we might term this a 'voluntary departure' or perhaps even a 'voluntary death.'"[32] Aaron's "death is voluntary in the sense that he submitted to God's decision" that it was time for him to die![33] They speculate that "whether Moses himself took a hand in his own death or not is left unclear, though it might well be implied," and then say, "The point we want to emphasize here is that the distinctions tend to be blurred between a request that God take one's life, God's determining the time of death, and one's taking a hand to carry out such a choice or decision."[34]

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[31]Arthur J. Droge and James D. Tabor, *A Noble Death: Suicide and Martyrdom among Christians and Jews in Antiquity* (San Francisco: Harper, 1992).

[32]Ibid., pp. 61-62.

[33]Ibid., p. 62.

[34]Ibid., p. 63.

IV. Debates within the early church about martyrdom and appropriate responses to religious persecution demonstrate that the church rejected the right of the individual to end his or her life to avoid illness[35]

Christians have reacted to persecution in four different ways: 1) apostatizing; 2) fleeing; 3) accepting whatever penalties that were inflicted, including death; and 4) volunteering for or provoking martyrdom. The first of these was always condemned and the third always approved during the patristic period.[36] The second and the fourth were much more problematic and evoked considerable disagreement within the Christian community especially between rigorists and moderates.

The preponderance of known cases of martyrdom that occurred before the legalization of Christianity in 313 are of those who did not actively seek martyrdom but, when arrested, were martyred rather than apostatize, or who, as spectators of others who were being interrogated, tortured, or executed, identified themselves as Christians and suffered the consequences.[37]

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[35]The numerous issues that make the subject of martyrdom in early Christianity complex are only tangential to our present concerns and, hence, must not detain us here. There is a continually expanding literature on martyrdom and persecution in early Christianity. Still the most authoritative and reliable treatment is W. H. C. Frend, *Martyrdom and Persecution in the Early Church* (Oxford: Blackwell, 1965).

[36]Some groups that were peripheral to the orthodox community, e.g., the Gnostics, maintained that apostasy — even a cavalier denial of one's beliefs — was acceptable if death were the alternative, since what one said under duress was irrelevant to the condition of one's heart. The reaction of the orthodox community to such a perspective was unequivocally condemnatory.

[37]This is not to say that there were not some who actively sought to provoke pagans to martyr them. *Indisputable* examples of such, however, are extremely rare. Droge and Tabor are hard pressed to provide many except by the most contorted hermeneutical gymnastics, and their claim that most Christian martyrs deliberately volunteered or died by their own hand is entirely unsubstantiated.

There is an even greater scarcity of recorded instances of those who actively took their own lives as a means of martyrdom. The extremely small number of Christians who are recorded as actively taking their own lives before the legalization of Christianity in 313 did so only under extreme duress. There are three categories:

1. Those who killed themselves to avoid being arrested and subjected to extreme suffering. Only one instance appears in the sources. It is recorded by Eusebius (ca. 265-339) and occurred during the "Great Persecution" (303-312):

> Need I rekindle the memory of the martyrs at Antioch, who were roasted over lighted braziers, not roasted to death but subjected to prolonged torture? Or of others who plunged their hands right into the fire sooner than touch the abominable sacrifice? Some of them were unable to face such a trial, and before they were caught and came into the hands of their would-be destroyers, threw themselves down from the roofs of tall houses, regarding death as a prize snatched from the scheming hands of God's enemies.[38]

Eusebius records this incident with neither approval nor disapproval. As we shall see below, Ambrose (ca. 339-97) implicitly and Jerome (ca.345-ca.419) explicitly condemn suicide to avoid the tortures that typically attended martyrdom.[39] Both, however, were born decades after the legalization of Christianity, but Eusebius lived through the "Great Persecution." This may suggest why the latter does

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[38]*The History of the Church from Christ to Constantine*, G. A. Williamson, trans. (New York: Penguin, 1965), 8.12.2 (p. 342).

[39]Ambrose, *Concerning Virgins* 3.7.32; Jerome, *Commentarius in Ionam prophetam* 1.6.

not condemn the act. Augustine (354-430) was extremely thorough in his various analyses of suicide. Yet he makes no reference to this category of self-killing although he appears to have scoured both pagan and Christian literature for references to suicide. Hence, it is reasonable to conclude that such types of suicide by Christians had occurred very rarely while Christians were still a persecuted minority.

2. Those who had already been arrested but dramatically ended their lives before being executed. Two examples are recorded by Eusebius: The first occurred in Alexandria in 249 under Decius:

> Next they seized the wonderful old lady Apollonia, battered her till they knocked out all her teeth, built a pyre in front of the city, and threatened to burn her alive unless she repeated after them their heathen incantations. She asked for a breathing-space, and when they released her, jumped without hesitation into the fire and was burnt to ashes.[40]

The second was during the "Great Persecution":

> There was a conflagration in the palace at Nicomedia, and through a groundless suspicion word went round that our people were responsible. By imperial command God's worshippers there perished wholesale and in heaps, some butchered with the sword, others fulfilled [*teleiō* = perfected, made perfect or complete] by fire; it is on record that with an inspired and mystical fervour men and women alike leapt on to the pyre.[41]

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[40]Eusebius, *History of the Church* 6.41.7, p. 276 in Williamson's translation.

[41]Ibid., 8.6.6, p. 334.

3. Virgins and married women who committed suicide to avoid defilement. The earliest examples appear to be from the "Great Persecution." Nearly a century after the legalization of Christianity, Rome was captured and ravaged by Alaric and his Goths who raped pagan and Christian women alike. Some Christian women committed suicide to preserve their chastity. It is a consideration of such suicides that prompted Augustine to write a lengthy but diversionary discussion of suicide in book one of his *City of God.*

The fact that the early church was sometimes ambivalent about the act of killing oneself to avoid extreme physical torture during state persecution, or killing oneself to preserve chastity in the face of immanent ravishing by barbarians, hardly demonstrates a generalized acceptance of suicide. Indeed, the terms in which the early church debated issues related to martyrdom demonstrates an implicit rejection of an individual right to suicide. All Christians held that martyrdom was the most perfect display of love toward God and was to be desired above any other form of death. Never could any other form of death provide the spiritual glory and rewards that martyrdom guaranteed. Accordingly, for moderates (a strong majority in our sources), who condemned seeking or provoking martyrdom, *the very basis for their condemnation of actively contriving that one most coveted form of death would* eo ipso *preclude 1) their approving of one's intentionally ending one's own life through some lesser means, much less 2) their formulating a theological justification for taking one's own life by one's own hand.* For rigorists (a minority in our sources), who approved of volunteering for martyrdom, *any form of death, including suicide, would be an obstacle to that one most cherished form of death, martyrdom.* Hence, it is not surprising that *in the entirety of extant patristic literature written before the legalization of Christianity, there is not even*

one recorded instance of Christians' committing suicide after having failed to provoke pagans to martyr them.

V. Augustine's rejection of suicide was based upon the same presuppositions and values that had caused the earlier church fathers to condemn suicide

In sections 16-28 of book one of the *City of God* Augustine condemns the following motivations for suicide: 1) to avoid or escape from temporal problems; 2) to avoid or escape from another's sinful actions (including doing so to preserve chastity); 3) because of guilt over past sins; 4) because of a desire for heaven; and 5) to avoid sinning. If there were any conceivably justifiable cause for suicide, Augustine says, it would be the last, but yet even the sin of such a well-motivated suicide would be greater than any sin that one might avoid by killing oneself. The basis of his condemnation of suicide in book one of the *City of God* is fourfold:

1. Scripture does not expressly permit, much less command, suicide as a means of achieving heaven or as a way to escape or avoid evil.

2. A prohibition of suicide is explicit in the sixth commandment.

3. Since no private party has the authority to kill a criminal who deserves capital punishment, those who kill themselves are homicides.

4. Suicide allows no opportunity for repentance.

His only reference to martyrdom in this digression on suicide is his refutation of pagan approval of suicide to avoid captivity. He argues that the patriarchs, prophets, and apostles did not commit suicide to escape persecution or martyrdom. About a decade before he published the first installment of the *City of God*, Augustine had devoted some attention to martyrdom, not that of Catholics persecuted by pagans, but rather to the courting of

martyrdom by, and, when unsuccessful, the theatrically spectacular suicides of, members of a schismatic group, the Donatists.[42]

The Donatist movement (named after its earliest leader, Donatus) had been formed in the early fourth century by rigorists who condemned the church's accepting back into fellowship those who had apostatized during the "Great Persecution." Donatists viewed themselves as upholders of the purity of discipline in the face of Catholic "compromise with the world" that they viewed as having worsened since the legalization of Christianity. From its very beginning, the movement was a thorn in the flesh for the Catholic leadership. Persecution of the Donatists by the Catholic Church and by the imperial government began in 317. Finally, in 415, the death penalty was enacted for those Donatists who continued to assemble. It was especially then that some Donatists, primarily a fringe group known as the Circumcellions, increased their indiscriminate as well as systematic acts of violence against Catholics (even once attempting to ambush and kill Augustine) and their provoking the authorities to put them to death. Some Donatists staged sensationalistic suicides as well.

Intermittently, for nearly twenty years, Augustine composed anti-Donatist treatises. A frequent focus of these was the Donatists' attitude toward and practice of suicide. Space permits only a brief summary of the major themes in his anti-Donatist writings that do not occur in his digression on suicide in book one of the *City of God*:

1. Provoking martyrdom is a form of suicide and hence a sin.

2. "Heroic" suicide by those who are unable to provoke others to martyr them is a sin.

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[42]On the Donatist movement see W. H. C. Frend, *The Donatist Church* (Oxford: Clarendon, 1952).

3. The Donatists' suicides violate the foundational Christian principle of patient endurance. This argument is presented in one of his last anti-Donatist writings (*Letters* 204, composed in 420).

In 415 Augustine had written a treatise entitled *De patientia*, in which, without specifically naming the Donatists, he chides them with the example of Job's endurance.[43] Patient endurance will prove to be the climax of Augustine's final statement on the subject of suicide, in book 19 of the *City of God*, published in 426 or 427.

The theme of patient endurance was, of course, not unique to Augustine. Even a casual reading of the church fathers shows that they saw suffering as an essential component of God's sanctifying work. This conviction, coupled with a firm belief in divine sovereignty, and an equally firm confidence that God does all things for the ultimate good of his people engendered in them a sense of responsibility to preach and practice endurance in the face of all afflictions. An outstanding, but not atypical, example is Cyprian (ca.200-258). Writing to his fellow Christians while the city was being ravaged by plague, he comments on the phenomenon that some of them were troubled because this

> disease carries off our people equally with the pagans, as if a Christian believes to this end, that, free from contact with evils, he may happily enjoy the world and this life, and, without having endured all adversities here, may be preserved for future happiness. . . . But what in this world do we not have in common with others as long as this flesh . . . still remains common to us?

As examples he gives famine, the devastation of war, drought, shipwreck, "and eye trouble and attacks of fever

[43]Augustine, *Letters* 13.10, in *FC* 16:246.

and every ailment of the members we have in common with others as long as this common flesh is borne in the world."[44] He reminds his readers that this

> endurance the just have always had; this discipline the apostles maintained from the law of the Lord, not to murmur in adversity, but to accept bravely and patiently whatever happens in the world. . . . We must not murmur in adversity, beloved brethren, but must patiently and bravely bear with whatever happens.[45]

Hence, "the fear of God and faith ought to make you ready for all things," such as loss of possessions, sickness, loss of loved ones. So

> let not such things be stumbling blocks for you but battles; nor let them weaken or crush the faith of the Christian, but rather let them reveal his valor in the contest, since every injury arising from present evils should be made light of through confidence in the blessings to come. . . . Conflict in adversity is the trial of truth.[46]

Cyprian consistently emphasizes the activity of God and the passivity of Christians in death. He asserts that Christians who died of the current plague "have been freed from the world by the summons of the Lord."[47] Later he avers that "those who please God are taken from here earlier and more quickly set free, lest, while they are tarrying too long in this world, they be defiled by contacts with the world." He then advises that "when the day of our own summons comes, without hesitation but with gladness we may come to the Lord at His call." For "rescued by an earlier departure, you are being freed from

[44]Cyprian, *Mortality* 8, in *FC* 36:204-5.
[45]Ibid., 11, p. 207.
[46]Ibid., 12, p. 208.
[47]Ibid., 20, p. 215.

ruin and shipwrecks and threatening disasters!" Hence, "Let us embrace the day which assigns each of us to his dwelling, which on our being rescued from here and released from the snares of the world, restores us to paradise and the kingdom." He encourages them to consider their loved ones already in heaven and the joys that await them there. "To these, beloved brethren, let us hasten with eager longing! Let us pray that it may befall us speedily to be with them, speedily to come to Christ."[48]

It is God who calls; it is He who issues the summons. God takes Christians from the world; God frees them; God rescues them; God releases them; God restores them to heaven. Christians are passive — they *are being* freed; they *are being* rescued; they *are being* released; they *are being* restored. It is God who is the active party. Christians are to yearn for heaven and to pray for an early departure from life. Yearning for death and praying to die are categorically different from taking one's own life. There is no room here for suicide. Patient endurance of all afflictions, perseverance to the end, final resignation to God's will in the midst of those very circumstances that God is using to test and refine the Christian: such thought is antithetical to the taking of one's own life. And such thought permeates patristic literature.

Did Augustine formulate the Christian position on suicide? The answer must be an unequivocal "no." He based his condemnation of suicide most fundamentally on the same presuppositions and values that had caused the earlier church fathers to condemn the act. Recall the terms with which they had condemned it: it is opposed to the will of God (Justin); it is not lawful (*Epistle to Diognetus*); suicides are punished more severely than others (Clementine *Homilies*); it is not permitted (Clement); God punishes suicides more than homicides and we all justly re-

[48]Ibid., 26, pp. 220-21.

gard them with horror (John Chrysostom); nothing can be more wicked than suicide (Lactantius); the sin of abortion is compounded by the dangers of the procedures that render it virtually an act of attempted suicide (Basil); Christ will not receive the soul of a suicide (Jerome); Scripture forbids Christians to lay hands on themselves (Ambrose). Augustine was simply the first Christian on record to discuss the issue thoroughly, although a century earlier Lactantius had already devoted several pages of his *Divine Institutes* to suicide and then amplified his treatment of the subject in his *Epitome.*

CONCLUSION

Although Judge Reinhardt is eager to regard early Christian martyrs as suicides, he balks at the use of the expression "physician-assisted suicides":

a. "While some people refer to the liberty interest implicated in right-to-die cases as a liberty interest in committing suicide, we do not describe that way. We use the broader and more accurate terms, 'the right to die,' 'determining the time and manner of one's death,' and 'hastening one's death' for an important reason. The liberty interest we examine encompasses a whole range of acts that are generally not considered to constitute 'suicide.' "[49]

b. ". . . we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as 'suicide.' . . . . We believe that there is a strong argument that a decision by a terminally ill patient to hasten by medical means a death that is already in process, should not be classified as suicide. Thus, notwithstanding the generally accepted use of the term 'physician-assisted suicide,' we have seri-

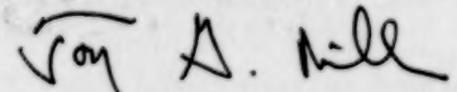
[49]*Compassion in Dying,* 79 F.3d at 802.

ous doubt that the state's interest in preventing suicide is even implicated in this case."[50]

Nevertheless, to Judge Reinhardt martyrs are suicides. The Reverend Martin Luther King, Jr. asserted, "He who has nothing for which he is willing to die is not fit to live." Was King's refusal to stop his work in the face of death threats suicidal? Durkheim, Alvarez, and, apparently, Judge Reinhardt would respond in the affirmative. The former two would almost certainly regard one's taking of a lethal dose of medication in the face of terminally illness as suicide. Judge Reinhardt would not.

In short, Judge Reinhardt's treatment of the issue of suicide in early Christianity is so historically and conceptually muddled as to be fundamentally inaccurate.

Respectfully submitted,



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[50]Ibid., at 824.

APPENDIX

Abbreviations

AF. *Apostolic Fathers*, K. Lake, trans. (Cambridge: Harvard University Press, 1912-13)

ANF. *Ante-Nicene Fathers*, [various translators] ([various dates]; reprint, Grand Rapids: Eerdmans, 1951)

FC. *Fathers of the Church*, [various translators] (Washington, D.C.: Catholic University of America, 1948-)

NPNF-1. *Select Library of Nicene and Post-Nicene Fathers of the Christian Church*, [various translators], 1st ser. ([various dates]; reprint, Grand Rapids: Eerdmans, 1976-79)

NPNF-2. *Select Library of Nicene and Post-Nicene Fathers of the Christian Church*, [various translators], 2d ser. ([various dates]; reprint, Grand Rapids: Eerdmans, 1976-79)

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No. 96-110

IN THE

Supreme Court Of The United States

October Term, 1996

STATE OF WASHINGTON, *et al.*,

Petitioners,

vs.

HAROLD GLUCKSBERG, *et al.*,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE RUTHERFORD INSTITUTE AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the United States Constitution grants or gives individuals a constitutional right to commit suicide and therefore, whether states should be allowed to prohibit physician assisted suicide.

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ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE RUTHERFORD INSTITUTE AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

The Rutherford Institute, ("TRI") respectfully submits this brief as *amicus curiae* in support of Petitioners' position that a state may ban physician assisted suicide. Pursuant to Sup. Ct. Rule 37.2, the parties have consented to the filing of this brief. TRI has filed its Sup. Ct. R. 37.2 written consent with the Clerk of this Honorable Court.

INTEREST OF THE AMICUS CURIAE

This case presents important issues affecting the fundamental right to life of all Americans. The American legal tradition has placed the preservation, protection and prolongation of life at the highest level -- the point of sacredness. The right to life is enshrined in both the Fifth and Fourteenth Amendments as well as the Declaration of Independence. Respondents attempt to greatly reduce the inherent value of the most precious and basic American right. The

Rutherford Institute opposes this attempt to undercut the value of human life.

The Rutherford Institute, (hereinafter "TRI") is a non-profit religious based civil liberties organization that defends the rights of persons of all religious faiths throughout the United States on a *pro bono* basis. TRI defends school children that wish to pray before school, trains attorneys in First Amendment litigation, addresses pro life issues and educates the general public regarding various religious legal issues. J.W. Whitehead, *The Rights Of Religious Persons In Public Education*, 333 (Crossway Books, 1991). Protecting the religious rights for all Americans in the face of direct attack on those rights is the interest of TRI.

SUMMARY OF ARGUMENT

There is no constitutional right to physician assisted suicide under the Fourteenth Amendment of the U.S. Constitution and thus states should be allowed, under the Tenth Amendment of the U.S. Constitution to regulate and prohibit this form of homicide just as states regulate other social protection measures and moral issues such as seatbelt laws, sexual relations with minors and motorcycle helmet laws.

ARGUMENT

Whether the United States Constitution grants or gives individuals a constitutional right to commit suicide and therefore, whether states should be allowed to prohibit physician assisted suicide.

U.S. Solicitor General, U.S. Attorney General, New Dealer, Associate Justice of the U.S. Supreme Court and now prophet Robert H. Jackson once said:

> This Court has gone far toward accepting the doctrine that civil liberty means the removal of all restraints...and that all local attempts to maintain order are impairments of the liberty of the citizen. The choice is not between order and liberty. It is between liberty with order and anarchy without either. There is danger that, if the Court does not temper its doctrinaire logic with a little practical wisdom, it will convert the constitutional Bill of Rights into a suicide pact.

Terminello v. City of Chicago, 337 U.S. 1, 37 (1949), (Jackson dissenting). Although Mr. Justice Jackson spoke in figurative terms, today this Honorable Court must decide if it wishes to literally enter into and approve a suicide pact with Jack Kervorkian. To meet the terms of this pact, this Honorable Court must reject a pre-existing national pact with the citizens of the United States which states:

> We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain *unalienable* Rights, that among these are *Life*.

The Declaration of Independence at Preamble (U.S. 1775). *Emphasis added.* TRI respectfully asserts that a pact with this nation that stands as the lynch-pin premise of this government should leave state statutes prohibiting physician assisted suicide alone. *See* U.S. Const. amend. X.

"In the West, both church and state have historically assumed roles in the control of suicide". Reich, 5 *Encyclopedia of Bioethics*, "Suicide" 2448 (MacMillan, 1995). Saint Augustine condemned suicide as a violation of God's great gift of life. O. Russell, *Freedom to Die: Moral and Legal Aspects of Euthanasia*, 77 (1976). Aiding and abetting a suicide or attempted suicide is a crime in all U.S. jurisdictions. *The Guide To American Law*, "Suicide" 428 (West, 1984). Prior to the two cases before this Honorable Court, no constitutional right to commit suicide existed. Reich, *Encyclopedia of Bioethics*, "Suicide" 2448 (MacMillan, 1995). The American Medical Association still adheres to its view that physician assisted suicide is improper -- even as the current

debate rages on. *The Guide To American Law*, "Biomedical Ethics" 38 (West Supp. 1995).

It is basic "black letter" law that states have an interest in preventing suicides and that courts have traditionally made a distinction between a terminally ill patient refusing food/medicine for themselves and a patient taking active steps to kill themselves. 22A Am. Jur. 2d "Death" sec. 582 at pages 552 to 554. Assisting or encouraging another to commit suicide has been considered a state criminal offense in America for over two centuries. *See generally*, 40 A.L.R. 4th 702 at sec. 6 (Law Co-Op Supp. 1996), citing *Commonwealth v. Bowen*, 13 Mass. 356 (1816) *et al.* To adopt Respondent's argument that tradition and common law allow physician assisted suicide means that long-standing precedent must be ignored. *See*, *Cruzan v. Director, MO. Health Dept.*, 497 U.S. 261, 294-295 (1990), (Scalia, concurring). As a matter of fact, to adopt Respondents' argument means that America embraces views that justified death camps in Nazi Germany! See Alexander, "Medical Science Under Dictatorship", 241 New Eng. J. Med. 39 (1949) where Dr. Leo Alexander, famed expert of the Nuremberg War Crimes trials, said "...it all started with the acceptance of the *attitude*, basic to the euthanasia movement, that there is such a thing as a life not worthy to be lived". *See also*, *The Holy Bible*, 1 Sam. 31:4-6. Contrary to the views of the Second and Ninth Circuits[1] in the pending cases before this Honorable Court, (*Vacco* and *Glucksberg*), "[t]hat which is not just is not law". *Eigen & Siegel*, *The MacMillan Dictionary of Political Quotations*, Ch. 50 "Justice" at 311 n. 26 (MacMillan, 1993). *Accord*,

[1] It is interesting to note that Mr. Justice Jackson, who warned of the proverbial "suicide pact" in *Terminello* was from New York and the Circuit Justice for the Second Circuit where the *Vacco* case originates. [*See e.g.*, 93 L.Ed. at page iv].

"An act against natural equity is void". *Id.* at 312 n. 46.[2] *See also*, *Catechism of the Catholic Church*, at sec. 2280 and 2281.

The gist of TRI's argument is articulately presented by Mr. Justice Scalia's concurrence in *Cruzan v. Director, MO. Health Dept.*, 497 U.S. 261 (1990). Mr. Justice Scalia made the following observations:

A) this Honorable Court should not interfere with Xth Amendment state issues such as suicide, *Cruzan*, 497 U.S. at 293.

B) states have the authority to prevent suicides, *Cruzan*, 497 U.S. at 293 and Ala. Code sec. 13A-3-4; and

C) no "substantive due process" claim can be made without a clear showing of a historically acknowledged protected interest and no such interest exists in the area of suicides. *Cruzan*, 497 U.S. at 294-295.

Mr. Justice Scalia noted that no right to kill oneself existed at the time of William Blackstone; it does not exist today; and no justification exists for a future modification of the long-standing rules regarding suicide. *Cruzan*, 497 U.S. at 296-300. More importantly, Justice Scalia correctly noted that the question of how a state addresses and regulates physician assisted suicide is a state, not federal, issue. *Cruzan*, 497 U.S. at 293, *accord U.S. v. Lopez*, 514 U.S.___, 131 L.E.2d 626, 642-643 (1995) which stands for the proposition that the federal government should not arbitrarily expand federal police powers at the expense of states' rights.

A case that weighs heavily on the consideration of the case at hand is *Bowers v. Hardwick*, 478 U.S. 186 (1986). In *Bowers*, this Honorable Court found that no constitutional "privacy" right to commit homosexual acts exists. *Bowers*,

[2] Note 26 quote William Lloyd Garrison, noted Civil War abolitionist and newspaper editor. Note 46 quotes James Otis, a member of the Colonial Massachusetts legislature.

478 U.S. at 190-191. More relevant to the case at hand is the finding that "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution". *Bowers*, 478 U.S. at 194. The Court went on to remind Americans that states do have the power to set moral laws for the citizens of its states. *Bowers*, 497 U.S. at 196. The logic of *Bowers*, that a state can dictate basic morals, applies equally to the moral dilemma of denying a patient physician assisted suicide.

In the area of a government setting minimal standards of moral decency. Some examples are:

1) The Mann Act. 18 U.S.C. sec. 2421 to 2424;
2) Statutory rape statutes. *See e.g.*, Tenn. Code Ann. sec. 39-13-506; Ala. Code sec. 13A-6-61(a)(3) and Ky. Rev. State. 510.050; and
3) Contributing to the delinquency of minors statutes, *See e.g.*, Tenn. Code Ann. sec. 37-1-156 and Ala. Code sec. 12-15-13.

Governments even set mandated minimal standards for wearing seatbelts in automobiles, *See e.g.*, 49 U.S.C. sec. 30127(d) and Ala. Code sec. 32-5B-1 *et seq.*, and the wearing of motorcycle helmets. *See e.g.*, Tenn. Code Ann. sec. 55-9-302 and Ala. Code sec. 32-12-42. States clearly have the power to mandate morality rules in the area of physician assisted suicide and the federal government should not infringe into this Xth Amendment states' rights area.

In closing, TRI respectfully takes issue with the Respondents' implicit claim that anybody who has ever faced a terminally ill family member's painful death would support physician assisted suicide. The author of this brief lost his father to progressive cancer which arose in 1991. The funeral took place on Father's Day, 1993. In the final stages of his life, (two years), Mr. Smith faced constant pain and mental delusions. After careful consideration, TRI's counsel still opposes physician assisted suicide. Obviously, this small example circumvents Respondents' claim that "everybody is on our side". Physician assisted suicide is morally wrong and should be outside of the purview of federal judicial intervention. *Cf.*, *Dick v. N.Y. Life Ins. Co.*, 359 U.S. 437, 442-443 (1959) for an acknowledgment by this Court of a valid statutory presumption *against* suicide. Every criminal statute in America sets a minimum base for acceptable morals. As noted in *Bowers*, "...if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed". *Bowers*, 478 U.S. at 196. It is unjust, impractical and illogical to find laws making physician assisted suicide unconstitutional simply because said laws make a moral choice to declare that facilitating an intentional killing is a crime.

CONCLUSION

The opinions of the Second and Ninth Circuits should be overturned as no constitutional right to physician assisted suicide exists under the U.S. Constitution.

This is the 11th day of November, 1996.

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No. 96-110

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

State of Washington, Christine O. Gregoire,
Attorney General of Washington,

Petitioners,

vs.

Harold Glucksberg, M.D.,
Abigail Halperin, M.D., Thomas A. Preston, M.D.,
and Peter Shalit, M.D., Ph.D.,

Respondents,

ON WRIT OF CERTIORARI TO THE U.S. COURT OF APPEAL
FOR THE NINTH CIRCUIT

BRIEF OF THE DISTRICT ATTORNEY OF MILWAUKEE COUNTY, WISCONSIN AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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November 8, 1996

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ISSUE PRESENTED

Whether the Due Process Clause of the Fourteenth Amendment to the United States Constitution forbids the State of Washington from uniformly prohibiting assisted suicide.

INTEREST OF *AMICUS CURIAE*

Amicus E. Michael McCann has served as District Attorney of Milwaukee County for 28 years. District Attorneys in Wisconsin "prosecute all criminal actions," §978.05(1), Wis. Stats. Under §940.12, Wis. Stats., assisting a suicide is a Class D Felony punishable by up to a $10,000.00 fine or 5 years in prison or both. Although this brief is submitted in his official capacity as District Attorney of Milwaukee County, the author does not purport to speak for Milwaukee County or the State of Wisconsin on the issues discussed herein. The purpose of this brief is to discuss physician-assisted suicide from the perspective of a public prosecutor, and to identify for the Court issues related to criminal law and criminal procedure.

Discovery of a constitutional right to death would rewrite the law of homicide. It can hardly be criminal to help another to exercise a constitutional right. Surely we may not prosecute those who merely assist others in effectuating choices so fundamental as to garner the protection of substantive due process. What is more, there is really no special expertise--

medical or otherwise--necessary to achieve the object of this asserted "right," *viz.*, death. Anyone can assist, and anyone will. Thus, consent of the victim will become a defense to murder.

Such a radical departure from hundreds of years of legal precedent will cause grave practical difficulties in the enforcement of our homicide laws. The Milwaukee County District Attorney's Office charges about 135 homicides each year, and in about two-thirds of these the killer is related to or knows the victim. Nationally, only about 25% of homicide victims are known to be killed by strangers.[1] In many cases, there are no eyewitnesses to the killing itself, a fact which makes the prospect of having to prove absence of consent in a homicide prosecution quite problematic.

SUMMARY OF ARGUMENT

Were this Court to discover a constitutional right to assisted suicide, the legal and practical consequences of that holding would be astonishing. First, the right to assisted suicide would necessarily extend constitutional immunity to those human agents who administer and implement the suicide "right"--i.e., the people who kill or help kill the one who wishes to die. This means voluntary euthanasia would be constitutionally protected, and consent would be a defense to homicide. Because the majority of

[1]U.S. Dept. of Justice (F.B.I.) "Crime in the United States" (US G.P.O. 1993), p.20.

homicides are perpetrated by spouses, family members, friends, or other acquaintances, and typically without other witnesses present, prosecutors would face an enormous practical obstacle in overcoming a defendant's claim that the victim asked to be killed, Consent defenses in rape cases burden the prosecution and victims, but at least the victim is normally available to rebut such a defense. Consent defenses in homicides would severely burden the prosecution and traumatize the family of the deceased--without the victim being able to refute the allegations of consent.

Recognition of a right to suicide would also confound law enforcement efforts to protect those in danger of suicide. Everyone in the criminal justice system, from the police officer who intervenes to rescue a would-be suicide to the prosecutor seeking civil commitment for the self-destructive, would suddenly have to tiptoe around the constitutional "right" to slay one's self.

In sum, creation of a right to assisted suicide would be gravely mischievous, disruptive of fundamental premises of the civil order, and deleterious to the public peace. This Court must reverse the pernicious decision of the court below.

I. A RIGHT TO ASSISTED SUICIDE WILL NECESSARILY ENTAIL A RIGHT TO EUTHANASIA

There is no material difference between handing a suicidal person a lethal prescription and handing that

same person a loaded pistol. There is, likewise, no material difference between pouring a lethal solution into the suicidal person's glass and pouring a lethal solution into that person's IV tube or feeding tube. In all of these cases, the suicidal person obtains death because of deliberate actions of another person. To say that a constitutional right to assisted suicide encompasses only unassisted administration of the means of death would be like saying a woman has a constitutional right to abortion, but only if she does it herself--without assistance from physicians, nurses, or others. This is why the right to *suicide* (to kill one's self) necessarily entails the right to *euthanasia* (to be killed).

The Ninth Circuit readily acknowledged that assisted suicide and euthanasia come together as a package:

> We would be less than candid, however, if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. * * * We consider it less important who administers the medication than who determines whether the terminally ill person's life shall end.[2]

[2]Compassion in Dying v. Washington, 79 F.3d 790, 831-832 (9th Cir. 1996).

The Ninth Circuit acknowledged that its decision would result in euthanasia:

> We recognize that, in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them.[3]

As examples of "those whose services are essential" to suicidal patients, the court suggests "the pharmacist who fills the prescription; the health care worker who facilitates the process; [and] the family member or loved one who opens the bottle [of pills]."[4]

The Ninth Circuit also seemed to recognize that the "fundamental right" it discovered would not be limited to competent patients, since third party consent, through the mechanism of "substituted judgment," could extend this "fundamental right" to incompetent patients:

> Finally, we should make it clear that a decision of a duly-appointed surrogate decision maker is for all legal purposes the decision of the patient himself.[5]

[3]*Id.* at 831 (footnote omitted).

[4]*Id.* at 838 n.140.

[5]*Id.* at 832 n.120.

Finally, with breathtaking nonchalance, the Ninth Circuit noted dismissively that limiting the suicide "right" to the terminally ill is not especially important:

> While defining the term "terminally ill" is not free from difficulty, the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined. Indeed, all of the persons described in the various statutes would appear to fall within an appropriate definition of the term.[6]

Citing its approval of various definitions that include a six-month time frame, no fixed time period, all permanently unconscious patients, and the definition contained in The Uniform Rights of the Terminally Ill Act (which includes insulin-dependent diabetics), the Ninth Circuit further reassures us that

> should an error actually occur it is likely to benefit the [non-terminal/incompetent] individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most desirable.[7]

Would any American court dare to opine, in the context of a capital punishment case, that erroneous

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[6] *Id.* at p. 831.

[7] *Id.* at 824 (footnote omitted).

imposition of the death penalty would benefit the *condemned*, by sparing him the miserable existence of life without parole?

II. A RIGHT TO ASSISTED SUICIDE WOULD FACILITATE HOMICIDAL ABUSE BY SPOUSES, FAMILY MEMBERS AND ACQUAINTANCES OF THE VICTIM.

Recognition of a right to assisted suicide would make the consent of the victim a defense to homicide. The defense of consent already creates serious difficulties for rape prosecutions, both in terms of challenges for the prosecutor and anguish for the victim.[8] In homicide cases, the victim cannot be called to refute a consent defense, creating severe proof problems for the prosecutor, as well as additional trauma for family and friends of the victim. Consequently, "mercy-killing" and the broad spectrum of other homicides commonly perpetrated by relatives and acquaintances would become virtually unprosecutable in many circumstances.

Our homicide statutes have historically protected the aged, disabled, or otherwise vulnerable. "Right to die" advocates often seem to assume that only benign, loving families will seek to bestow death as a benefit.

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[8] *See generally* Comment, The "Rough Sex" Defense, 80 J. Crim. L. & Criminology 557 (1989) (drawing comparison between problems caused by consent defense in rape cases and asserted consent defense in homicide cases).

Yet our society is one in which

> family violence is a crime problem of shocking magnitude. Battery is a major cause of injury to women in America. Nearly a third of female homicide victims are killed by their husbands or boyfriends. Almost 20 percent of all murders involve family relationships.[9]

In recent years our society has recognized that the frail elderly are often the victims of domestic abuse. Almost all states (including Wisconsin[10]) have enacted "elder abuse" statutes, to protect elderly and disabled persons from, primarily, *family members*. It would be these same family members who would have the greatest power to influence, and interest in influencing, a "voluntary" decision to commit suicide or be euthanized.[11]

Whose suffering, then, will really fuel suicide/euthanasia? The suffering of the victim or that of the victim's family and friends? The American

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[9]Report of Attorney General's Task Force on Family Violence, U.S. Dept. of Justice, 1984 at p. 10-11.

[10]Section 940.285, Wis. Stats.

[11]A 1986 study by the Family Research Laboratory of the University of New Hampshire (presented to the Gerontological Society of America) found a self-reported abuse rate of 32 per 1,000. Nationally, over 700,000 senior citizens are abused by family members: 58% by spouses and 24% by children. (Milwaukee Journal, January 23, 1986)

Association of Suicidology just released a report which recognizes this concern:

> There would appear to be no small risk that the socially and economically advantaged would find it economically tempting to encourage premature death for their disadvantaged counterparts, or that the poor, ignorant, and disadvantaged would be too ready to give up on themselves. * * * Inevitably, some family members would become enthusiastic for assisted suicide or euthanasia for reasons of personal gain.[12]

This same report noted the evidence that, even among the terminally ill, "suicidal ideation rarely occurs in the absence of a clinical depressive syndrome."[13]

> [L]ittle attention has been paid to the high likelihood of serious accidents inherent in such a scenario. Vomiting may occur as the patient slips into a coma, with aspiration of the vomitus. Should isolated patients change their minds, they may nevertheless choke to death in a panic, or, if rescued, die of

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[12]"Report of the Committee on Physician-Assisted Suicide and Euthanasia," 26 *Suicide and Life-Threatening Behavior*, Supp. 1996, p. 8.

[13]*Id.* at 11.

pneumonia . . .[14]

Just a short time after this report was released, the media reported the case of a 29-year-old student in Boise, Idaho, who apparently changed his mind after swallowing a lethal dose of medicine. Unfortunately for the young man, he drove himself to a "medical center" that was closed and was found dead at the locked door the next morning.[15]

The fact that not all suicides result in peaceful and idyllic "passing" in the company of a loving, committed family was brought home last August by the bizarre details of the death of Judith Curren--Jack Kevorkian's 35th victim. Ms. Curren was a 42-year-old registered nurse who had two daughters (7 and 9) and a troubled marriage to her former psychiatrist. Only *after* Kevorkian attended her death (by lethal injection) on August 15, 1996, did he learn: (1) her autopsy showed no sign of physical disease other than obesity; (2) she had been taking amphetamines, Xanax, Serax, and Oxycodone before her death; (3) police had responded to domestic calls 9 times in her last eight months of life; and (4) she had obtained an injunction in 1993 against her husband--who had been arrested for domestic battery just three weeks before he accompanied his wife to Kevorkian's "solution" to her

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[14]*Id.* at 15.

[15]"Man Changes Mind Too Late to Prevent Suicide," Milwaukee Journal Sentinel, Oct. 31, 1996.

"chronic fatigue syndrome."[16]

III. CONSENT AS A DEFENSE TO HOMICIDE: HISTORICAL BACKGROUND AND FOUR EXAMPLES

Historically, consent has been rejected as a defense to homicide in the United States. Legal scholars have written that consent cannot be a defense to homicide because the State has an interest in preserving public order and the life and safety of its citizens.[17]

> [A] criminal offense is a wrong affecting the general public, at least indirectly, and consequently cannot be licensed by the individual directly harmed. Thus, it is no defense to a charge of murder that a victim, upon learning of the defendant's homicidal intentions, furnished the defendant with the gun and ammunition.[18]

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[16]Compiled from New York Times, 8/20/96; Reuter News Service, 8/19/96; Detroit News, 8/30/96, Dr. Curren told the media afterward that his life was now easier, and that "The hard part was living with it, with all my wife's problems." Oakland (MI) Press, 9/1/96.

[17]J. H. Beale, Jr., Consent in the Criminal Law, 8 Harv. L. Rev. 317, 325 (1894-5); Comment, The "Rough Sex" Defense, 80 Crim. J. L. & Criminology 557, 564 (1989).

[18]LaFave & Scott, Substantive Criminal Law, 687, sec. 5.11(a) (1986).

Consent has been considered in sentencing as a mitigating factor.[19] Some courts have also allowed the victim's consent to be admitted on the issue of the defendant's state of mind.[20] But consent has never been a defense to the crime itself.

Any constitutionally-recognized "right to death," therefore, inevitably and inexorably brings in its wake a Pandora's Box of problems related to prosecution of intrafamily and other homicides. (*Amicus* has included as an appendix a listing of some recently-reported prosecutions to illustrate this problem.) If a person has a right to assisted suicide, that person can consent to be slain, and we have created a legally-recognized consent defense to homicide. Anyone who does not believe such defense strategies will become routine underestimates the "ingenuity" of the criminal defense bar. Consider the following examples:

EXAMPLE A

In March, 1985, Rosewll Gilbert shot and killed his 73-year-old wife, who had osteoporosis and Alzheimer's. At his trial, he testified that he shot his wife, Emily, from behind without discussing his plan with her, because he couldn't stand to put her in a nursing home. He also admitted:

> Sure, I know I was breaking the law but there seems to be things more important than the law, at least to me in my private tragedy. So it's murder. So what?[21]

After being convicted of murder and sentenced to life in prison, Gilbert argued in his appeal that Emily's complaints constituted a "mercy will" which the jury should have been instructed to consider. The Court of Appeals of Florida was unpersuaded, holding that

> Euthanasia is not a defense to First Degree Murder in Florida . . . In the case at hand there was no evidence that Emily left a mercy will. It is ridiculous and dangerous to suggest, as appellant does, that a constructive mercy will was left when Emily (or anyone else who is sick) said/says, "I'm so sick I want to die." Such a holding would judicially sanction open season on people who, although sick, are also chronic complainers.[22]

EXAMPLE B

In 1988, Nora Broomall and Cecil Booher were convicted of the contract killing of Broomall's husband; Booher had contended at trial that he only assisted the

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[19]Paul H. Robinson, Criminal Law Defenses, 315 (1984).

[20]**People v. Matlock**, 336 P.2d 505, 508-10 (Cal. 1959).

[21]**Gilbert v. Florida**, 487 So. 2d 1185, 1188 (Ct. App. 1986)

[22]*Id.* at 1189.

victim, at the victim's insistence, in committing suicide so that his wife could collect his life insurance benefits. Broomall then requested the following jury instructions:

> (b) I charge you that the consent of the victim may be a defense to murder if the defendant in the instant case had no evil disposition toward the victim but acted only at the victim's own earnest request to save him from what the victim considered to be a greater evil.
>
> (c) Suicide is not a crime in the State of Georgia.[23]

The Georgia Supreme Court, in rejecting Broomal's instruction, noted that

> the gist of these requests to charge is to suggest to the jury that certain conduct, involved in aiding the commission of a suicide, may not amount to malice, and consequently would not support a malice murder conviction."[24] * * *
> While in this state there is no statutory proscription relative to suicide, nor aiding suicide, we do not view a killing by consent of, or at the request of, the victim to be "legal."[25]

[23]**Broomall and Booher v. State**, 260 Ga. 220, 222, 391 S.E.2d 918, 921 (1990).

[24]*Id.* at 223, 391 S.E.2d at 921 (footnote omitted).

EXAMPLE C

In a recent Wisconsin prosecution for First-Degree Intentional Homicide,[26] defendant Michael Bartz testified at trial that the victim, his friend, was despondent (because he was about to go to prison for 6 years), wanted to commit suicide, and had brought a sawed-off shotgun and walked with Bartz into a field. Bartz called 9-1-1 after the victim's death and told responding officers how he had held the gun for his friend so that his friend could pull the trigger and thus carry out his wish. Bartz appealed his conviction--and life sentence with no parole for 40 years--arguing that the trial court erred in not instructing the jury on assisted suicide as a lesser-included offense.[27] Although Bartz's conviction was upheld on appeal, the appellate court relied upon the specific forensic facts of the case in holding that the failure to give an instruction on assisted suicide as a lesser included offense was not error.[28]

[25]*Id.* at 223 n.4, 391 S.E.2d at 921 n.4.

[26]**State v. Michael Bartz**, Walworth County Circuit Court, #93-CF-226, April 1994.

[27]"Reasonable minds could differ on whether it was murder or a friend assisting a friend to end his own life." Petition for Review, **State v. Bartz**, #95-2345-CR, at 12.

[28]Unpublished Decision #95-2345-CR, filed August 7, 1996.

EXAMPLE D

On Sunday, May 12, 1996, in Springfield, Illinois, John McCreery and his family decided that they did not want to be a financial burden to their relatives. They settled upon a bizarre suicide plot, in which a knife was purchased for each of the five family members and the father, John McCreery, ended up dead. His 22-year-old son, Shannon McCreery, has been charged with First Degree Murder for slashing his father's throat in a Springfield hotel room after his father had slashed his abdomen and said he wanted to die. This case is presently set for trial on December 9, 1996, and the defense will be that Shannon, "at most", assisted a suicide.[29]

IV. SUICIDE AS A CIVIL RIGHT

Recognition of a constitutional right to assisted suicide would create additional problems for law enforcement. Police officers routinely intervene to forcibly seize and detain--and even civilly commit--suicidal citizens.[30] Wisconsin Law explicitly permits the use of force against another "if the person reasonably believes that to use such force is necessary

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[29]"Mystery Surrounds Hotel Killing," Springfield State Journal-Register, May 14 & Sept. 26, 1996.

[30]Section 51.15, Wis. Stats. *See also* Ch. 55, Wis. Stats. (Protective Services).

to prevent such person from committing suicide."[31] In 1975, the Minnesota Supreme Court held that

> there can be no doubt that a bona fine attempt to prevent a suicide is not a crime in any jurisdiction, even where it involves the detention, against her will, of the person planning to kill herself."[32]

If, however, this Court were to recognize a constitutionally-protected right to suicide, would law enforcement's traditional response to suicide attempts trigger civil rights liability?

On September 5, 1996, a local police officer received a hero's treatment in the local press for risking his own safety to push a despondent man off railroad tracks "just seconds before the train whizzed past at 75-80 mph." The officer's department commended his heroism for preventing the suicide, and the man was taken against his will to the psychiatric ward of a local hospital.[33] Just three days later, police officers in neighboring Michigan were criticized and labeled "thugs" after interrupting a hotel meeting between Jack Kevorkian and a despondent 60-year-old woman who

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[31]Section 939.48(5), Wis. Stats.

[32]**State v. Hembd**, 305 Minn. 120, 126, 232 N.W.2d 872, 878 (1975).

[33]"Officer Praised for Saving Man from Train," Milwaukee Journal Sentinel, September 5, 1996.

died the next day.[34] Other than the comparative esthetics of seeking death by high-speed train versus death by the medically trained, how is a police officer to distinguish between the exercise of a constitutional right and the commission of a desperate, but unprotected, act?

On October 22, 1996, 46 year-old Kathy Change doused herself with gasoline and burned herself to death in front of 50 people on the University of Pennsylvania campus in Philadelphia. She explained her motivation as follows:

> My real intention is to spark a discussion of how we can peacefully transform our world. I offer myself as an alarm against Armageddon and a torch for liberty.[35]

Ought Ms. Change's audience to have intervened to save her or facilitated her constitutional right to death (*and* expression) by providing the matches? Is Kathy Change's sacrificing herself for what she perceives as the value of her message legally and constitutionally any more repugnant than a cancer patient killing herself to avoid what she perceives as being a burden to her family? Which is a legitimate exercise of liberty?

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[34]"Woman Kills Self A Day After Police Raid," Milwaukee Journal Sentinel, September 8, 1996.

[35]"Woman Sets Herself on Fire to Draw Attention to Beliefs," Milwaukee Journal Sentinel, October 27, 1996.

This same difficulty will plague efforts to seek civil commitment for those who are bent on self-destruction.[36] A state may civilly commit a mentally ill person who is dangerous to himself.[37] If there is a right to suicide, will the State have to prove, by clear and convincing evidence, not only the *risk* of suicide but also its "irrationality"? How is the State to distinguish between rational depression and irrational depression without making judgments about quality of life--i.e., whether that particular life is worth living?

Presently, in Wisconsin alone, there are 755 prison inmates serving life sentences.[38] Nationally, there are many thousands of such inmates--a large portion of them awaiting execution. If our Constitution provides a fundamental right to death for somebody who wants to avoid short-term suffering, must it not also provide a fundamental right to death for a "lifer" or death-row inmate who has no chance of release? To permit an assisted suicide for somebody with a serious illness or disability, but not for a convicted murderer on death row, would be to give priority in death to

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[36]Section 51.20 Wis. Stats.

[37]**Addington v. Texas**, 441 U.S. 418 (1979); *see also* **O'Connor v. Donaldson**, 422 U.S. 563, 574 n.9 (1975) (listing "foreseeable risk of self-injury or suicide" as example of dangerousness to self).

[38]Resident Population Data Report of the Wisconsin Department of Corrections, Sept. 30, 1996.

those with illness and/or disability--a bizarre result.[39]

CONCLUSION

Transformation of the traditional crime of assisted suicide into a constitutional right would not only be a prosecutor's nightmare, but also a killer's dream. This Court should vigorously disavow this misuse of the Constitution.

The judgment below should be reversed.

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[39]Prior cases have held that prisoners have no right to fast to death. *E.g.*, In re **Caulk**, 125 N.H. 226, 480 A.2d 93 (1984); **State ex rel. White v. Narick**, 292 S.E.2d 54 (W.Va. 1982). Recognition of a right to suicide would call these decisions into question, permitting convicts to use the threat of exercising this new "right" as a weapon against prison discipline and moral. *See* Caulk, 125 N.H. at 231, 480 A.2d at 96.

SELECTION OF RECENT PROSECUTIONS FOR MERCY KILLINGS

DATE	PLACE	DESCRIPTION
October, 1952	Roseburg, Oregon	Thomas Bouse sentenced to death for drowning his wife in the bathtub--despite his claim that his wife "was tired of living" and had asked to die. (199 Ore. 676)
September, 1957	Los Angeles, California	Earl Matlock sentenced to death for strangling a man that he claimed asked him to do it (because he only had six months to live and didn't want his death to look like suicide).(51 Cal.2d 682)
February, 1980	Lawrence, Kansas	Kathleen Cobb sentenced to life for First Degree Murder; shot her long-time friend in the head after he injected himself with an overdose of cocaine and told her "make sure I'm dead." Instruction on Assisted Suicide was denied; conviction affirmed. (229 Kan. 522)
May, 1981	Danville, Illinois	Robert Mueller, M.D. and his wife Pamela Schopp, R.N., charged with conspiracy to murder their newborn conjoined twins by withholding oral feedings for 9 days. Case later dismissed. (N.Y. Times, 7/2/81)

April, 1982	Houston, Texas	Attorney William Chanslor, convicted of Solicitation to Murder his wife (42; stroke); paid an undercover cop $2,500 for "undetectable poison." The Texas jury sentenced him to 3 years prison. (Newsweek, 8/16/82) ***See 108 for detailed description**
February, 1983	Los Angeles, California	Thomas C., 16, found delinquent for Second Degree Murder for shooting his sister (14; depressed) because "she begged me to kill her. I didn't want to. I loved her so." (183 Cal. App. 3rd 786)
March, 1983	Houston, Texas	Billy Ray Clore shot his father (62; comatose) in a nursing home, was convicted of Attempted Murder and received 3 years probation. (Milw. Journal, 7/19/83)
June, 1983	Harvey, Illinois	Daniel McKay, a veterinarian, killed his newborn son (cleft palate) by smashing his head on the delivery room floor. Two trials for murder ended with hung juries. (N.Y. Times, 2/18/85; Milw. Journal, 1/31/88)
August, 1983	Ventura County, California	Joseph G., 16, found by California's Supreme Court to have aided a suicide rather than murder his friend (16) by entering into a "suicide pact" and driving a car over a cliff. (34 Cal. 3rd 429)

February, 1984	Newburyport, Massachusetts	Victoria Knowlton, RN, acquitted of Attempted Murder for turning off respirator of patient (59; ALS). (National Law Journal, 10/29/84)
August, 1984	Richfield, Wisconsin	Michael Duychak shot and killed his mentally ill sister (30) and was sentenced to life in prison. (Milw. Journal, 9/5/84)
January, 1985	Benbrook, Texas	Michael Goodin convicted of Murder for shooting a woman he claimed was depressed and "talked him into it." (726 S.W.2d 956)
March, 1985	Ft. Lauderdale, Florida	Roswell Gilbert convicted of First Degree Murder for shooting his wife (73; Alzheimer's) and sentenced to life in prison. (Time, 5/27/85; 487 So.2d 1185)
April, 1985	Los Angeles, California	John Kappler, M.D. (anesthesiologist) charged with Attempted Murder for turning off the respirator of a patient (28; quadriplegic). (Milw. Journal, 5/14/85)
July, 1985	New York, New York	Kurt Semel acquitted by a judge of Murder and Manslaughter, for suffocating his wife (72; lung cancer). (Milw. Journal, 8/15/85)

July, 1985	Spotsylvania County, Florida	Linda Lou Seal turns herself in after fatally shooting her father (68; cancer), saying "I had to do it. He was suffering so." Convicted of First Degree Murder. (Florida Star)
December, 1985	Richmond, California	Edward Baker was charged with Assault and False Imprisonment for forcing a nurse at gunpoint to disconnect a respirator from his father (69; cancer), who died ten minutes later. (Milw. Journal, 12/26/85)
January, 1986	St. Petersburg, Florida	Dr. Peter Rosier, a pathologist, acquitted of killing his wife (43; lung cancer). (Newsweek, 11/7/88)
April, 1986	Atlantic County, New Jersey	Joseph Hossman, MD, killed his mother-in-law (81; Alzheimer's) by injecting Demerol into her feeding tube. Convicted of Manslaughter; two years probation, $10,000 fine, 400 hours com. service; medical license reinstated after a 6-month revocation. (New Jersey Star Ledger)
May, 1986	Media, Pennsylvania	Irene Bernstein shot and killed her 2-year-old, brain-damaged son. She was convicted of Third Degree Murder and sentenced to 5 years probation and community service. (Milw. Journal, 11/19/87)

February, 1987	Adams County, Wisconsin	Frank Reinl shot and killed his terminally ill wife; allowed to plead guilty to Second Degree Murder. (Milw. Journal, 10/20/88)
August, 1987	Cincinnati, Ohio	Nurses' Aide Donald Harvey sentenced to life in prison after pleading guilty to killing 25 nursing home patients, explaining "I visualize myself being in that same position, and lying there and suffering for years, and no one cared to come and see me. And I thought I'd put them out of their misery, like I hope someone would put me out of my misery." (Milw. Journal, 8/23/87)
October, 1987	DeKalb County, Georgia	Nora Broomall and Cecil Booher convicted of murdering Broomall's husband--who Booher claimed asked to be killed so his wife would get his insurance money. (260 Ga. 220)
November, 1987	Mount Holly, New Jersey	Frederick Wisniewski charged with Manslaughter for shooting a man who had attempted suicide 5 times before--allegedly in exchange for $40,000.00 and a new Mercedes-Benz. (Milw. Journal, 1/30/88)

February, 1988	Alexandria, Minnesota	Oscar Carlson went to nursing home and shot wife (71; Alzheimer's). He pled guilty to Second Degree Murder and received a 3 1/2 year prison sentence. (Milw. Journal)
March, 1989	Miami, Florida	Jean Arias, R.N., charged with Solicitation to Commit Murder for recruiting another nurse to poison a 5-week-old infant (brittle bone condition). (Miami Herald)
April, 1989	Chicago, Illinois	Rudy Linares given conditional discharge for Unlawful Use of Weapon; holding nurses at bay with a .357 Magnum after disconnecting respirator from his son (15 mos.; coma). A grand jury refused to indict on First Degree Murder. (Milw. Journal, 5/19/89)
December, 1989	Chicago, Illinois	Gerald Williams charged with First Degree Murder for killing his wife, who had multiple sclerosis and "begged him to end it." (Milw. Journal, 12/26/89)
June, 1990	Munnsville, New York	Adelbert Ward charged with the mercy killing of his older brother. (Milw. Journal, 6/26/90)
August, 1990	Detroit, Michigan	Bertram Harper suffocates wife (69; cancer) with plastic bag. Acquitted. (Milw. Journal, 5/10/91)

October, 1990	Milwaukee, Wisconsin	Patricia Rosio convicted by jury of Reckless Homicide for starving her son (11; cerebral palsy); placed on probation--after the *jurors* requested leniency. (Milw. Co. Circuit Court Case #F-913178)
August, 1993	Walworth County, Wisconsin	Michael Bartz sentenced to life in prison for shooting his friend, who was despondent, suicidal, and brought a gun to the scene. (Circuit Court Case No. 93-CF-226)
October, 1993	Jonesboro, Georgia	Dr. Eva Carrizales charged with Murder in the death of a terminally ill 5 1/2 week old baby. (New York Times, 11/12/93)
April, 1996	Brookfield, Wisconsin	William Volkmann charged with the First Degree Murder of his wife 75-year-old wife. He stated he shot his wife in the head after she fired her home health worker. (Milw. Journal, 4/12/96)
May, 1996	Springfield, Illinois	Shannon McCreery charged with First Degree Murder for slashing the throat of his father--who had just slashed his own abdomen and told his family that he wanted to die. (Newsweek, 9/2/96)

Case of the Willing Victim

He called his plot to poison his wife "a mission of mercy," an attempt to end the pain and suffering caused by a paralyzing stroke she had three years ago. She backed his story, insisting in dramatic and emotional testimony that she wanted to die: "I begged and pleaded with him to help me, to get something that would help [kill me]." But the jury was unmoved: last week William Chanslor, 50, a prominent Houston attorney and past president of the city's Trial Lawyers Association, was convicted of "solicitation to murder" his 42-year-old wife, Sue.

The plot was bizarre even by Texas standards. It began last year when Chanslor, using the alias John O. Thompson, advertised in paramilitary journals for an "expert in poisons & chemical agents with access to same." In one of those magazines, Soldier of Fortune, he spied an ad for a five-volume set of books entitled "How to Kill," written by a Canadian weapons expert (box). He purchased the books and arranged to contact the author, John Minnery, at his Ontario home. Between October and March of this year, the two men had about a half-dozen telephone conversations about poison. Chanslor first inquired about killing animals, then revealed that his intended victim was human—42 years old and partially paralyzed in a wheelchair.

When Chanslor asked Minnery to procure poison for him, Minnery went to the police. The two men finally met in April at the Toronto airport, where Minnery introduced the Texan, still using his alias, to Keith Symons, an Ontario provincial policeman posing as a man with access to poisons. During an hourlong conversation in the airport lounge, taped and photographed by Canadian police, Chanslor detailed his mission. When asked whether the victim might cooperate by committing suicide, he lamented, "It's an impossibility. We talked about it once and then the person backed out . . . It's gone on too long, too long . . . I'm sick of waiting, for this bitch is really getting to me."

After discussing several poisons and rejecting them—because they leave traces—the men decided on ricin, a toxin more powerful than cobra venom; it is extremely rare and produces a slow, convulsive death. It is also virtually impossible to detect: Minnery assured Chanslor that an autopsy would attribute the death to a stroke, heart attack or uremic failure. Chanslor said he planned to give the poison to the victim at bedtime and inquired how long he should wait before calling his neighbors for help. "Eight to ten hours," Minnery informed him.

Vitamin C: Less than two weeks later, Symons flew to Houston and, this time under video surveillance by Texas authorities, delivered to Chanslor a yellow capsule (which actually contained vitamin C) along with a surgical mask, gloves and tweezers to ensure that he didn't touch or inhale the "poison." After Chanslor paid the cop $2,500 and got into his 1981 Lincoln, police surrounded the car and arrested him.

The defense didn't dispute the facts, only their interpretation—arguing that mercy, not murder, was on Chanslor's mind. The Chanslors tried to bolster that view by a public display of devotion throughout the eight-day trial; he wheeled his wife into the courtroom during the trial, and she sat as close to him as possible. On the stand, they echoed each other, maintaining that their complex scheme to make her death appear natural stemmed from the fear that their son, Brandon, would be stigmatized by his mother's suicide. But Assistant District Attorney Jim Lavine dismissed the mercy defense as "a kaleidoscope of deception" and Mrs. Chanslor's testimony as pathetic self-deception. He introduced statements from Mrs. Chanslor, made on the day of her husband's arrest, that she had never asked him to provide her with a way to die and that she wouldn't willingly take her own life. "He wanted to kill his wife because she was a yoke, a burden to him," Lavine argued. "The mission of mercy is for him, not her."

The jury took only three hours to return its verdict. Mrs. Chanslor took the stand again, this time pleading that her husband not be sent to prison: "I can't live without him." Chanslor himself begged the jury not to separate him from his family because "they can't make it without me, and I can't make it without them." In the end, Mrs. Chanslor's mercy mission proved far more successful than her husband's. The jury rejected prosecution arguments for a prison term of 16 to 20 years and sentenced Chanslor to just three years in prison, making him eligible for parole in one year. "Mrs. Chanslor was devastating," conceded Lavine. Agreed his fellow prosecutor, Brad Beers, "If it wasn't for her testimony, he would have gotten 20 years."

MARK STARR with DAN SHAPIRO in Houston and PAULA CHIN in New York

(37) (39)

Nos. 96-110 and 95-1853

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, *Petitioners*,

v.

HAROLD GLUCKSBERG, *et al.*, *Respondents*.

DENNIS C. VACCO, Attorney General of New York, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*, *Respondents*.

On Writs of Certiorari
to the United States Courts of Appeals
for the Ninth and Second Circuits

BRIEF OF FAMILY RESEARCH COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[*]

Family Research Council, Inc., is a non-profit research and educational organization dedicated to the preservation and defense of traditional values and the family. The Family Research Council believes in the incomparable value of every human person, regardless of age or infirmity. Among the chief guardians of this principle in any society is a medical profession dedicated above all else to the preservation of human life and the equal dignity of all persons. In the opinions below, the Second Circuit and Ninth Circuit have struck a blow against the foundational ethic of medicine: that doctors must not kill. In so doing, both courts advance the unsupported contention that allowing a small measure of physician-assisted killing will advance the dignity of the dying process and have no adverse effects on the ethics of the medical profession or its dedication to preserve human life.

Other *amici*, chiefly the American Medical Association, the American Psychiatric Association, and the American Suicide Foundation, address why this contention is false in light of the contemporary medical environment. In this brief, Family Research Council invites the Court to consider the relevance of history's most tragic experience of physician-assisted death: the German euthanasia program of the 1930s and 1940s. This experience demonstrates the risks of corruption of the medical profession in particular and civil society at large inherent in implementing physician-assisted killing. Failure to heed the lessons of history's most calamitous experience in this area would be tragic. For the sake of American families and the integrity of this nation, this is a risk that should not be imposed in the guise of a newly-found right under either the Equal Protection or Due Process clauses of the Fourteenth Amendment.

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[*] This brief is submitted with the written consent of all parties, filed with the clerk of this Court.

SUMMARY OF ARGUMENT

Under Germany's "euthanasia" program of the 1930s and 1940s, the lives of hundreds of thousands of terminally ill, incurably sick, and mentally incompetent patients were terminated by physicians who accepted the notion that there are lives not worthy to be lived. While the lessons to be learned from this chapter of history will never be free from controversy, certain facts are both indisputable and highly relevant to the question of whether any nation should enshrine a right to physician-assisted killing in its fundamental charter of rights.

First, the erosion in medical ethics that made possible the participation of German physicians and health care workers in the widespread killing of asylum patients and other "incurables" was not of Nazi, fascist, or even peculiarly German origin. The prospect of killing the chronically sick and disabled was widely discussed in Germany, and elsewhere, long before the rise of the Third Reich.

> There was nothing creative or innovative about Nazi social policy in this regard. The Nazis were consistent and effective in the implementation, but responsibility for the origins of their policies rested with others—the medical profession, the scientific community, and the intelligentsia generally.

Hugh Gregory Gallagher, By Trust Betrayed: Patients, Physicians, and the License to Kill in the Third Reich 95 (1990).

Second, those guilty of crimes relating to euthanasia defended their actions at the time, at their trials, and, in the case of those who escaped serious punishment, in later years, by citing the compassionate and humanitarian motive of ending lives classified as *lebensunwerten Leben*. While the Nazi dictatorship (and, eventually, the War) provided the

conditions necessary for such killings to be carried out on a wide scale, the concept of "life unworthy to be lived" made doctors voluntary and willing participants in these events.

Third, those involved in the investigation and prosecution of these crimes confirmed their "small beginnings," and warned against the consequences of accepting similar notions in other societies.[1] Euthanasia's "small beginnings" so thoroughly corrupted German medicine that it could not resist becoming a key component of the Nazi killing machine. It is imprudent at best to presume that such "small beginnings" would not have a corrosive effect on the medical profession in this nation.

For many reasons, physician-assisted death as a purported "cure" for human suffering would be "a medical, moral, and social disaster." Daniel Callahan and Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 Rich. L. Rev. 1, 4 (1996). Alleviating the suffering of the afflicted by the infliction of

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[1] In the foreword to his book, *Die Unfähigkeit zu trauern* (1977) (The Inability to Mourn), Dr. Alexander Mitscherlich, a German psychiatrist who attended the "Medical Case" Nuremberg trial, *United States v. Karl Brandt, et al.*, and prepared an abstract of the evidence and proceedings for the West German Physicians' Chambers, warned that

> Today in many minds, there is a reluctance to accept the facts of history. This inclination or attitude is in some way similar to the fantasies which permeated the Third Reich. What happened in the years of the Third Reich remains alive in our subconscious, dangerously so. It will be fatal for us to lose touch with the truth of what happened then. We must struggle to seek out the truth of that era, rather than search for improved defenses to hide us from this truth.

Quoted in Gallagher, *By Trust Betrayed, supra* at 274.

death is a practice wholly unworthy of protection by the Constitution of the United States.

ARGUMENT

I. THE HISTORY OF "EUTHANASIA" IN NAZI GERMANY IS RELEVANT TO THE ISSUE OF WHETHER ASSISTED SUICIDE SHOULD BE RECOGNIZED AS A CONSTITUTIONAL RIGHT.

The prohibition against physicians participating in causing the death of their patients is ancient in origin and universal in scope. Even in the Netherlands, the only nation in the world to tolerate euthanasia on a large scale, the criminal prohibitions against the practice have not been repealed. Only two jurisdictions—the Northern Territory of Australia and the State of Oregon—have formally decriminalized assisted suicide. Otherwise, the laws of every nation reflect the attitude of anthropologist Margaret Mead when she described the Hippocratic Oath's proscription on physicians killing their patients as a benchmark of our civilization:

> [T]his is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer -- to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . [I]t is the duty of society to protect the physician from such requests.

Margaret Mead, Personal Correspondence, *quoted in* Maurice Levine, *Psychiatry and Ethics* 324-25 (1972).

This century has witnessed both the propagation and abhorrent consequences of an opposing ideal: the notion that, due to infirmity, suffering, or lack of consciousness, there is such a thing as a life not worthy to be lived, and hence a

responsibility on the part of the law to permit physicians to end such lives in a humanitarian manner.

Movements to legalize euthanasia are more than a century old. In the early part of this century, particularly in the years between World War I and World War II, the issue gained notoriety and support in several nations. American legal scholars such as Herbert Wechsler and Jerome Michael supported the legalization of voluntary euthanasia, and a bill to this effect was debated in the House of Lords in 1936. Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 Minn. L. Rev. 969, 970, 1014-1018 (1958); Robert Proctor, *Racial Hygiene: Medicine Under the Nazis* 177 (1988). Public opinion was divided, Kamisar, *supra* at 1029, while elite figures such as certain Nobel Prize winners and professors at Harvard, Cornell, and elsewhere argued for "the privilege of death" for those "who wish to die." Proctor, *Racial Hygiene*, *supra* at 180.

Euthanasia also was advocated in Germany. As early as 1895, a widely-used German medical textbook made a claim for "the right to death." Michael Berenbaum, *The World Must Know: The History of the Holocaust as Told in the United States Holocaust Memorial Museum* 64 (1993). Immediately following World War I, the notion took greater root in the German medical and legal professions, instigated largely by publication by Professors Karl Binding and Alfred Hoche of *Die Freigabe der Vernichtung lebensunwertens Leben* (Permitting the Destruction of Unworthy Life) (1920). *See* 8 Issues in Law & Med. 221 (1992) (Patrick Derr and Walter Wright, trans.) (copies of which have been lodged with the Court).

What transpired in Germany in the late 1930s and 1940s would unalterably change the debate over the ethics and legality of physicians participating in ending the lives of their

patients. In that period, the lives of hundreds of thousands of terminally ill, incurably sick, and mentally incompetent patients were terminated by German doctors—the elite of the profession in Europe—in a program of "euthanasia" propagated both by acceptance of the "unworthy life" thesis and by the imposition of National Socialist theories of eugenics derived from earlier concepts developed by the German medical profession and intelligentsia. Michael Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-1945* 93-97, 273-277, 284-285 (1994); Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* 44-79 (1986); Gallagher, *By Trust Betrayed, supra* at 74-95.

In the ensuing decades, the connection of medical killing in Nazi Germany to contemporary debates regarding the legalization of assisted suicide and euthanasia has been a matter of great controversy. Burleigh, *Death and Deliverance, supra* at 291-298.[2] It is clear, however, that those closest to these events saw some connection. The condemnation of the "Nazi doctors" was universal and prompted great reflection on the question of ensuring that their actions never be repeated. As one step, the world's physicians reaffirmed the foundational ethical principle of their profession: that doctors must not kill.[3] The cases before this Court are the most important juridical test since that time of the meaning of that principle. For this reason alone, the experience which influenced so much of what

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[2] *See also* Nat Hentoff, *et al.*, *Contested Terrain: The Nazi Analogy in Bioethics*, Hastings Center Rep., Aug.-Sept. 1988 at 29.

[3] The *Declaration of Geneva*, adopted by the General Assembly of the World Medical Association in September 1948, re-affirmed the key precepts of the Hippocratic tradition: "I will maintain the utmost respect of human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity." *See* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 331 (2d ed. 1983).

the world thinks today of the issue of euthanasia is relevant to the deliberations of this Court.

The acceptance by physicians of the notion of a "life not worthy to be lived" under the "euthanasia" program was a cornerstone of the horror that was to follow. Leo Alexander, *Medical Science Under Dictatorship*, 241 New Eng. J. Med. 39, 44 (1949). Without the willingness of doctors to participate, the euthanasia program would not have occurred. Patrick Derr, *Hadamar, Hippocrates, and the Future of Medicine: Reflections on Euthanasia and the History of German Medicine*, 4 Issues in Law & Med. 487 (1989). This "cornerstone" principle persists today. The experience of the Netherlands (described in the Brief of *Amicus Curiae* the American Suicide Foundation in No. 96-110) establishes that the participation of physicians in killing their patients invariably rests upon, and propagates, the notion of life unworthy of life. The writings of pro-euthanasia philosophers James Rachels, Peter Singer, and John Harris[4] confirm this fact. While social and political conditions in Western democracies obviously differ from those of post-World War I and Nazi Germany, the consequences of legalizing physician-assisted suicide and euthanasia will be no less dire.

II. THE GERMAN "EUTHANASIA" PROGRAM WAS CARRIED OUT BY A MEDICAL PROFESSION THAT VIEWED KILLING INCURABLE AND "MENTALLY DEFECTIVE" PATIENTS AS A HEALING ACT.

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[4] *See* James Rachels, *The End of Life* 77 (1986) (acknowledging that euthanasia is less about autonomny than about societal recognittion that certain human beings lack suffient human attributes to possess a "life"); Peter Singer, *Bioethics and Academic Freedom*, Bioethics (1990); John Harris, *Euthanasia and the Value of Life*, Euthanasia Examined: Ethical, Clinical and Legal Perspectives 6 (J. Keown ed. 1995).

A. Euthanasia in Germany Began with Proposals for Medical Killing, Under Strict Guidelines, of Defined Classes of Incurable Patients.

In interbellum Germany, the medical and legal professions were influenced by proposals that patients in certain categories would benefit from hastened death. In so doing, "the most humane, the most sophisticated, the most scientifically advanced medical community [in] the world" between 1920 and 1940 self-destructed formulating and promoting ideas of physician-assisted death. Derr, *supra*, 8 Issues in Law & Med. at 488. *See also* Proctor, *Racial Hygiene, supra* at 282-83; Lifton, *The Nazi Doctors, supra* at 45-51; Burleigh, *Death and Deliverance, supra* at 11-20. *Sterbehilfe*, "dying help," was advocated by the elite medical profession for the incurably sick and was considered to be *Wohltat*, a merciful act. Proctor, *Racial Hygiene, supra* at 178-79.

1. Hoche and Binding.

The Binding and Hoche work, *Permitting the Destruction of Unworthy Life,* advocated *Sterbehilfe* as a compassionate and humanitarian response for those who requested it, pursuant to a carefully controlled process. The text was "crucial" and "most important" in creating acceptance within the profession for direct medical killing, and for active participation in the euthanasia program that was to be instituted. Wertham, *The Geranium in the Window*, (1966), *reprinted in* Death, Dying & Euthanasia at 610-611(D. Horan & D. Mall, eds 1980); Lifton, *The Nazi Doctors, supra* at 45-58.

Prof. Binding was one of Germany's leading specialists in constitutional and criminal jurisprudence. Dr. Hoche was a psychiatrist. The jurist Binding queried: "Should permissible taking of life be restricted . . . to an individual's act of suicide as it is in current law, or should it be legally extended to the

killing of fellow human beings, and under what conditions?" 8 Issues in Law & Med. at 232. He answered affirmatively for three groups of persons: (1) "those irretrievably lost as a result of illness or injury, who, fully understanding their situation, posses and have somehow expressed their urgent wish for release"; (2) "incurable idiots" from whom "there is no valid consent to be killed" but whose lives are "completely without purpose" and "a fearfully heavy burden both for their families and for society"; and (3) formerly competent patients who, due to trauma, "have become unconscious and who, if they should ever again rouse form their comatose state, would waken to nameless suffering." *Id.* at 247-49.[5]

Hoche asked a somewhat different question, also answered affirmatively: "Is there human life which has so completely lost the attribute of legal value that its continuation has permanently lost all value both for the bearer of that life and for society?" *Id.* at 258. Hoche appeared to warn against a purely utilitarian approach:

> In the times of need which we now face, we will never stop caring for the physically defective or ill, so long as they are not mentally dead. We will never cease giving the best possible care to the physically and mental ill, so long as there is any prospect of improvement in their condition.

Id. at 262.[6]

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[5] As to this last group, Binding expressed doubt that "a standard procedure can be created for managing this groups of killings. Cases will occur in which killing seems actually fully justified; but it can also happen that the agent, in the belief that he acted correctly, acted precipitously." *Id.* at 250.

[6] What did Hoche mean by the "mentally dead"? He explained this condition in two ways. With respect to "external relationships," the mentally dead individual "lacks any productive accomplishments and lives in a condition of total helplessness, requiring care by another." *Id.* With respect to his "inner state," clear ideas, feelings, or acts of will cannot arise . . . no emotional links to the environment can arise (even though they may naturally be the object of the inclinations of someone else)." *Id.*

Binding and Hoche explicitly condemned mercy-killings which took place contrary to the will of the victim, and emphasized the consent of the victim as a necessary condition for the killing of incurably ill people.[7] With regard to his first defined category, Binding stressed that the only people who may be candidates for having their deaths permitted are those who are terminally ill and who "have either requested death or consented to dying." 8 Issues in Law & Med. at 262. [8] Consent was of crucial importance to Binding: "*every permitting of killing which requires violating the will to live of the actual or potential victim is ruled out.*" *Id.* (emphasis in original).

Hoche and Binding advocated providing *Sterbehilfe* in a carefully controlled process, with evaluation by a three-person panel of professionals and the ability of the person to withdraw consent at any time. *Id.* at 252. They recommended that the initiative be made by the patient in the form of an "application for permission." *Id.* The application would go to a government board composed of a physician, a psychiatrist, and a lawyer,

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[7] In general, euthanasia as described by Binding and Hoche and their German predecessors had a societal and statist component that distinguished it from the American tradition of individual rights, to which the current euthanasia movement adheres. *See* Lifton, *The Nazi Doctors, supra* at 47. The distinction, however, may be more sharp in theory than in practice. Contemporary euthanasia proponents do not rely exclusively on the autonomy of those whose lives would be ended, but on the notion that such persons have ceased to have a "life." *See* Rachels, Singer, and Harris, *supra* note 4. In the Netherlands, moreover, most physician-assisted deaths occur without the explicit request of the patient. *See* Brief *Amicus Curiae* of the American Suicide Foundation in No. 96-110.

[8] As for the third category, Binding considered as proper candidates those who "would (had they not fallen into unconsciousness at the critical time or if they had been able to achieve awareness of the situation) have requested or consented." 8 Issues in Law & Med. at 250.

and unanimity would be required in granting permission. *Id.* The decree of permission would indicate that a "thorough investigation" had been undertaken, that the patient "seems beyond help," and that "there is no reason to doubt the sincerity of his consent." *Id.*

Yet, Binding conceded that this orderly procedure would not always be followed: "Perhaps following it is not even thinkable. Perhaps following the procedure, even expeditiously, would entail unbearable suffering for the patient." *Id.* at 253. Binding considered the possibility that doctors would be faced with the choice of "consign[ing]" the patient to continued suffering and the family and physician "to complete passivity" during the application process, or allowing the "accomplices" to satisfy their "consciences" that the required conditions were present for permissible killing. He favored the latter: "Without hesitation, I endorse the second alternative." *Id.* The second alternative would result in punishment of the accomplice in the case of "unpardonable" error. *Id.*[9]

2. Response of the German Medical Community and the Impact of the Rise of Nazism.

The Hoche and Binding monograph was much debated by the medical community in Germany after its publication. The legalization of medicalized killing was discussed and rejected at the 1921 *Karlsruhe Ärztetag*, medical convention, and at the 1922 Dresden conference of the Society for Forensic Psychiatry. Burleigh, *Death and Deliverance, supra* at 24.

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[9] As to the possibility of error, Binding writes: "the possibility of error by the Permission Board is undeniable. . . . But error is possible in all human actions." *Id.* at 254. He concludes: "all other actions of sympathy also involve possible error and perhaps an evil outcome. But who would want to limit the application of this most beautiful feature of human nature by pointing out such possible error?" *Id.* at 255.

Critics from the medical community warned that "compassionate" release for the afflicted would only be the first step toward a new medical ethic of death. Dr. M. Beer wrote in his book, *Ein schöner Tod: ein Wort zur Euthanasie-frage* 9 (Barmen 1914)(A Beautiful Death: A Word About the Question of Euthanasia), that physician aid-in-dying might be

> the first step, but whether it would be the last appears to me to be very doubtful. . . . Once respect for the sanctity of human life has been diminished by introducing voluntary mercy killing for the mentally-healthy incurably ill, and involuntary killing for the mentally ill, who is going to ensure that matters stop there?

Burleigh, *Death and Deliverance, supra* at 15. Critics of Hoche and Binding also

> despised the "utilitarian shopkeeper" mentality which appeared to inform the tract . . . Others worried about the inflationary, slippery-slope potentialities latent in the whole enterprise. A few had doubts regarding the inherent arbitrariness and perniciousness of value judgments regarding the value of human life.

Id. at 21.

In a major response to Hoche and Binding, *Das Problem der Abkürzung "lebensunwerten" Lebens (1925) (The Problem of Cutting Short Life Unworthy of Living)*, Dr. Ewald Meltzer hotly disputed the claim that

> people with mental handicaps had lost the last vestiges of human personality, stressing instead their capacity and will to enjoy life. [He argued that it is] "far more heroic to accept these beings to the best of one's abilities, to bring sunshine into their lives, and therewith to serve humanity" than to kill them for utilitarian reasons . . . altruism was humanity's distinguishing feature, [and] asylums for handicapped people were not only valuable centres of scientific research, but also tangible manifestations of Christian charity.

Burleigh, *Death and Deliverance, supra* at 21-22 (citations omitted).

While Binding and Hoche "turned out to be the prophets of direct medical killing," their thesis remained a minority view within German psychiatry and medicine during the Weimar Republic. Lifton, *The Nazi Doctors*, *supra* at 48. The rise of the Nazis brought into power an ideology of eugenics that provided the environment for their thesis, with the willing cooperation of medical and academic leaders, to overcome the initial opposition. *Id.* at 22-44. The first manifestation of this policy of "negative eugenics" was the mandatory sterilization of the "unfit;" acceptance of medical killing was the critical second step. *Id.* at 42-44.[10]

3. Cultural Responses.

Eugenicist theories promoting sterilization and euthanasia were widely propagated in German society through education and other means. Among the most prominent means used was film. In his novel *Mission and Conscience* (1936), later a popular film entitled "I Accuse," Helmut Unger told a story of a young woman suffering from multiple sclerosis who believes that her life is no longer worth living and asks her physician husband to relieve her of her misery.

> In a grand act of humanity, the husband gives his wife a fatal injection of morphine, while a friend of his (also a

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[10] As a consequence of these developments, the Ministry of Justice proposed in 1933 that it "be made possible for physicians to end the tortures of incurable patients, upon request, in the interests of humanity." Gallagher, *By Trust Betrayed, supra* at 93. The penal code would be revised to permit physician aid-in-dying upon approval of a three-physician review panel. *Id.* The law was not enacted; indeed, at no time were German laws amended or repealed in order explicitly to legitimate medical killing.

> doctor) accompanies the act with soothing and romantic music at the piano. [When he is brought to trial for murder, the husband] refuses to let his colleagues invent an alibi for him, because he is convinced he has done no wrong. [He is] acquitted on grounds that his act constituted an act of mercy [and] in a critical scene, the words of the Renaissance physician Paracelsus are recalled: "medicine is love."

Proctor, *Racial Hygiene, supra* at 182-83.

Several other pro-euthanasia films were produced during this period. *See* Burleigh, *Death and Deliverance, supra* at 183-219. The films argued that a medical ethic of preserving life only caused unnecessary pain and misery; "we humans use science to prolong suffering, where we could use science to bring deliverance." *Id.* at 204 (quotation from film). Such an ethic, these films said, stemmed from an "exaggerated concern for humanity," combined with "a religion which is alienated from reality," and "the dictates of an outmoded legal code", and which ought to be abandoned. *Id.* at 201-05 (quotations from films). Later, the key role of such images in leading to the acceptance of medical killing became apparent.[11]

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[11] One of the persons involved in these physician-assisted death programs was Alfons Klein, supervisor at Hadamar Sanitorium. His attorney described the course of events leading up to wholesale slaughter.

> In a motion picture called "I Accuse" the problem of euthanasia, that is mercy killing, was expounded. This picture was simply a prelude for things to come, because shortly after the beginning of the war the government passed a law whereby people who were afflicted mentally should be put out of the way. . . . from January 1941 to July 1945, more than 10,000 German mental patients were killed in Hadamar alone.

The Hadamar Trial, infra at 220-21. Counsel for Hadamar defendant Dr. Adolf Wahlmann further described what has to happen in the elite German medical community.

> The opinion was held in important circles that people of so low a physical or mental standard that their lives were not worth living, and for whom there was no hope of recovery or of ability to work, should be removed after medical examination, especially when they themselves were a burden on their relatives and on the general public. . . . In Germany this point of view was put before the public through the media of books and movies, and was gradually recognized by widening circles.

The Hadamar Trial, infra at 226.

B. Direct Medical Killing Began With Permission for Physician-Assisted Death In the Cases of Incurable Infants and Adults and Rapidly Expanded to Other Categories of Patients.

The proposals of Hoche, Binding, and others in the German and international community in favor of physician aid-in-dying were put into practice in the 1930s. First, child euthanasia was permitted for disabled and "defective" infants and children. Soon thereafter, an adult program for an "easy death" for incurably sick and mentally ill Germans was instituted on grounds of compassion. Ultimately, the genocide that was the Final Solution grew out of these programs of medicalized killing.

This "euthanasia" program was motivated by a mixture of concerns, some statist and some humanitarian in nature. It is important to note, however, that racial and anti-Semitic sentiments played no role in the original design or implementation of this program. In fact, the German government "did not want to grant this philanthropic act to the Jews." *Brandt*, Nurem.Mil.Trib., *infra* at 877-80; Kamisar, *Non-Religious Views, supra* at 470; Gallagher, *By Trust Betrayed, supra* at 69 (Viktor Brack maintained, "the blessing of euthanasia should be granted only to [true] Germans"). "[I]t is worth remembering that the engine which drove the early moral transformation of German medicine was not the

ideology of racial discrimination, but medical economics." Derr, *supra,* 8 Issues in Law & Med. at 494.

> [The] moral collapse of German medicine was not caused by anti-Semitism. Ironically, [Jews] did not deserve the 'benefit' of psychiatric euthanasia. [Nor was the collapse] caused by National Socialist pressure. . . . the collapse did not begin with the hacks and quacks. It began at the top, with the heads of departments of academic medicine.

Id. at 488-89.[12]

Furthermore, it is critical to note that physicians were invited, not compelled or otherwise forced, to participate in this program. Gallagher, *By Trust Betrayed, supra* at 60. "Doctors were never *ordered* to murder psychiatric patients and handicapped children. They were *empowered* to do so, and fulfilled their task without protest, often on their own initiative." Proctor, *Racial Hygiene, supra* at 193; *see also* Gallagher, *supra* at 5, 46.

1. Merciful Deaths for Children.

The practice of euthanasia, as illustrated by two early cases, began with requests from individuals for physician-assisted death. In March 1937, a child was killed by his father because he was significantly mentally ill. When put on trial for murder, the local health office came to the father's defense, influencing the court to grant him a nominal prison sentence instead of the death penalty asked for by the prosecutor. Proctor, *Racial Hygiene, supra* at 182.

The next year, a man named Knauer wrote the German government asking that his blind and mentally retarded

[12] "It would be a mistake to call it a Nazi program. It was not. The program was conceived by physicians and operated by them. They did the killing." Gallagher, *By Trust Betrayed, supra* at 5.

daughter, born without an arm and leg, be granted *Gnadentod* (mercy death). The Chancellor instructed his personal physician, Dr. Karl Brandt, to investigate, and, if the letter were true, to grant the request. Proctor, *Racial Hygiene, supra* at 186; Burleigh, *Death and Deliverance, supra* at 93-96. Brandt found "a child who was born blind, an idiot—at least it seemed to be an idiot—and it lacked one leg and part of one arm." Gallagher, *By Trust Betrayed, supra* at 47; Proctor, *Racial Hygiene, supra* at 186. According to the testimony of Brandt, "The parents should not feel themselves incriminated at some later date as a result of this euthanasia—that the parents should not have the impression that they themselves were responsible for the death of this child." Alexander Mitscherlich, *The Death Doctors* (1962) (James Cleugh, trans.) at 234.

Many parents were eager to obtain the *Wohltat* of physician-assisted death for their ill, deformed, or disabled children and many "wrote to hospitals to ask if their child could be relieved of his or her misery and be granted euthanasia." Proctor, *Racial Hygiene, supra* at 194; Kamisar, *supra*, 42 Minn. L. Rev. at 1032-1033[13]

Both doctors and parents preferred to use euphemisms, to allow for psychological defense mechanisms of rationalization and denial of what really was happening. After taking a poll of parental opinion, it was determined by the government that, al-

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> The business of taking a sick child on a costly and fruitless round of visits to doctors and hospitals frequently seems to have worn down their patience. They had exhausted most of the options before they were promised specialist treatment for the child. . . . The initiative to consign a child to one of these clinics sometimes came from parents, some of whom, like the twenty-five-year-old mother of a blind and mentally handicapped four-year-old child, were already of the opinion that it would have been better if the child had died at birth.

Burleigh, *Death and Deliverance, supra* at 101.

though many supported *Gnadentod* for their severely disabled children, "parents would prefer it if they were told that their child had succumbed to this or that illness." Burleigh, *Death and Deliverance, supra* at 98.[14]

As many as 6,000 children were provided the "benefit" of euthanasia in this first phase of physician-assisted death in Germany. *Id.* at 111; Lifton, *The Nazi Doctors, supra* at 50, 56.

2. T-4 Program: Euthanizing of Terminally Ill, Disabled, and Mentally Incompetent German Patients.

The German government also received requests from adults with cancer and severe disabilities for a mercy death. Burleigh, *Death and Deliverance, supra* at 93. Numerous people, believing that they were acting with compassion, wished that their handicapped relatives could be "released from their suffering." Henry Friedlander, *The Origins of Nazi Genocide: From Euthanasia to the Final Solution* 171-72 (1995).

In May 1939, an advisory group, the Committee for the Scientific Treatment of Severe and Genetically Determined Illness, was formed to determine if and how a euthanasia program for children and adults would operate. Proctor, *Racial Hygiene, supra* at 186. The adult project was housed in Berlin at number 4 Tiergartenstrasse, giving rise to its code-name "T-4." In the beginning, there appeared to be a broad level of support for this throughout the country. *Id.* at 194.

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[14] Few parents, however, were as explicit as a woman who requested that the Ministry of the Interior "have her two 'idiotic children' taken to the asylum at Schleswig 'in order to carry out euthanasia." *Id.* at 102.

Patients then began to be euthanized by lethal injection at various hospitals and other health care institutions. The T-4 doctors did not consider themselves to be killers, but ministers of medical treatment, although there was some concern that their actions be accorded some legitimate legal authority. Friedlander, *The Origins of Nazi Genocide, supra* at 300.

In September 1939, the chancellor responded to pressure to provide legal immunity for the doctors engaged in *Gnadentod* mercy killings and he issued a memorandum stating that

> Reichsleiter [Philip] Bouhler and Dr. [Karl] Brandt, M.D. are charged with the responsibility of enlarging the authority of certain physicians, to be designated by name, in such a manner that persons who, according to human judgment, are incurable can, upon a more careful diagnosis of their condition of sickness, be accorded a mercy death.

United States v. Brandt et al., Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10, Nuremberg, October 1946-April 1947, Vol. II:196.

This edict, however, did not have the force of law, even under the standards of the Nazi regime. Burleigh, *Death and Deliverance, supra* at 112-113. Another law to explicitly legalize physician-assisted death was proposed in 1940. Like the version proposed in 1933, it provided that

> Anyone suffering from an incurable illness that leads to strong debilitation of either oneself or others can, upon explicit request of the patient and with the permission of a specifically appointed physician, receive dying help (*Sterbehilfe*) from a physician.

Proctor, *Racial Hygiene, supra* at 193; Burleigh, *Death and Deliverance, supra* at 98-99. An additional clause provided further that those people who were mentally incompetent to decide for themselves to exercise this new "right" were entitled to have others make that decision for them on their behalf. *Id.*

This law was never formally enacted because the decision was made "to keep the question of euthanasia a 'private matter'— between doctors and their patients." Proctor, *Racial Hygiene, supra* at 193. The German medical profession was determined to keep the practice in their hands alone. "The needle belongs in the hand of the doctor," said Viktor Brack, head of one euthanasia program in 1939. Karl Brandt agreed, stressing that "gassings should only be done by physicians." Proctor, *Racial Hygiene, supra* at 190.

Government legal authorities initially intended that the T-4 program's *Sterbehilfe* would be lawful only for "those cases where physicians, upon their personal decisions, [can] relieve incurably ill patients from their suffering by administering a drug for mercy killing." Lifton, *The Nazi Doctors, supra* at 138-39. Within a short period of time, "a network of some thirty killing areas within existing institutions was set up."[15] Lifton, *The Nazi Doctors, supra* at 54; Burleigh, *Death and Deliverance, supra* at 101. Morphine, scopolamine, and prussic acid (cyanide) injections were initially used for the T-4 project because they had more of a "medical aura" than gas. However, objections to use of carbon monoxide gas were soon overcome because, not only was it more efficient, but Brandt said that carbon monoxide was painless and it "would be the most humane form of death." Lifton, *The Nazi Doctors, supra* at 72

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[15] These hospitals and health-care facilities included Württemberg, Brandenburg, Hartheim, Sonnenstein, Hadamar, Leipzig-Dösen, Eglfing-Haar, Meseritz-Obrawalde, Tiegenhof, Langenhorn, Bernburg, Eichberg, Kalmenhof, Uchtspringe, Königslutter, Scheuern, Mainkofen, Am Steinhof, and Kaufbeuren. Friedlander, *The Origins of Nazi Genocide, supra* at 87-89, 95, 152-53, and 162. In fact, the killing secretly continued at Kaufbeuren, Eglfing-Haar, and a few other hospitals for months *after* the war ended and Allied forces assumed control. Gallagher, *By Trust Betrayed, supra* at 249-50.

In January 1940, Brandt, Brack and others conducted the first large-scale test of assisted death for incurable adults in a psychiatric hospital near Berlin. Proctor, *Racial Hygiene, supra* at 189-90. It was a gassing process, which "included a fake shower room with benches, the gas being inserted from the outside into water pipes with small holes through which the carbon monoxide could escape." Lifton, *The Nazi Doctors, supra* at 71.

What occurred in the adult program is exemplified by the hospital at Hadamar, one of the major T-4 institutions. Between January and August 1941, over 10,000 mentally ill Germans were provided a "painless death" in the shower-room gas chambers at Hadamar. *The Hadamar Trial: Proceedings of a Military Commission for the Trial of War Criminals,* Introduction at *xxiv* (E. Kintner ed. 1948).[16] An administrative supervisor at Hadamar was Alfons Klein. He testified at his war crimes trial that, from October 1940

> until January 1940 [The Hadamar] Institution was maintained only for German mental patients. In January 1941, plans were made to kill mental patients and to burn the corpses. This method was carried on and used until August 1941, when it was discontinued.

Id. at 69-70.

Heinrich Ruoff, chief male nurse who worked more closely with the patients, remembered that the T-4 program at Hadamar began slightly earlier.

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[16] Counsel for Hadamar physician Adolf Wahlmann insisted at his war crimes trial that, "in general, the people killed were those faced with a permanent illness, for whom a completely painless death was a relief," *The Hadamar Trial, supra* at 228. "Insane people are useless to society and as a rule do not endure pain . . . Incurable tubercular patients, on the other hand, have to suffer terrific pain," added counsel for Heinrich Ruoff. *Id.* at 233.

> In 1940 the program of killing started. Those people who were brought here were German mentally sick. These people were gassed to death and then burned. . . . During the year 1941, because of complaints from Germans, this work was eliminated.

Id. at 75.

As Ruoff said, by 1941, word began to spread of involuntary killings. So, in August 1941, the psychiatric/physician-assisted death program at Hadamar and the other T-4 hospitals were officially ordered to be discontinued. By this time, 80,000-100,000 people had been killed under the T-4 program. Lifton, *The Nazi Doctors, supra* at 192; Burleigh, *Death and Deliverance, supra* at 160. At Hadamar, however, the program never ceased. Only the method of death changed; another 3,500 were euthanized by lethal injection between August 1941 and August 1942. *The Hadamar Trial, supra* at Introduction *xxiv*.

Beginning in 1942, the program recommenced elsewhere, except instead of gas, injections and starvation were the method of inducing death, largely on a case-by-case basis. Proctor, *Racial Hygiene, supra* at 192.[17]

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[17] About this point in time it was decided that German-held territory would be populated only by Germans. Ideas were circulated regarding the issue of what to do with Jews. *United States, et al. v. Hermann Goering, et al.*, 6 F.R.D. 69, 119 (1946) (judgment of the International Military Tribunal). Early measures included a requirement that all Jews must wear the Star of David, which was decreed in September 1941. Friedlander, *The Origins of Nazi Genocide, supra* at 288.

German-Jews had their citizenship revoked and were treated as foreigners; policies were "directed towards the complete exclusion of Jews from German life." *Goering*, 6 F.R.D. at 127. Deportations of Jews from the German homeland did not begin until October 1941. Friedlander, *The Origins of Nazi Genocide, supra* at 288. Jews were rounded up and imprisoned, and their property was seized. The "original purpose [of the concentration camps] was to imprison without trial all those persons who were opposed to the Government, or who were in any way obnoxious to German authority." *Goering*, 6 F.R.D. at 117. It was not until later that "camps became places of organized and systemic murder." *Id.*

It was not until March 1941 that the Frankfurt "Institute for the Investigation of the Jewish Question," was inaugurated. B. Müller-Hill, *Murderous Science* 45 (1988). Even then, Auschwitz survivor Prof. Henry Friedlander reports, "the policy toward Jews did not yet include killings." Friedlander, *The Origins of Nazi Genocide, supra* at 21.

3. Genocide Under 14f13: "Special Treatment" for Jews and Other "Undesirables."

World War II caused a change in emphasis and an acceleration of the killing process. Resources were scarce, and it was perceived that the armed forces had a greater claim to food, clothing, and medicine than did the sick, mentally ill, and social undesirables. The government accordingly took advantage of the distractions of the war to eliminate these "burdensome" people.

"The original 'euthanasia' project, the killing of those who were seriously ill [T-4], was extended to killing virtually anyone whose death was desired." Lifton, *The Nazi Doctors, supra* at 255. First, hospitalized Jews who had previously been denied a mercy death were given *Sonderbehandlung*, "special treatment," and killed along with Germans in the euthanasia program. Later, it was ordered that Jews and other undesirables be transported from the concentration camps to the same killing centers used by the T-4 program. Lifton, *The Nazi Doctors, supra* at 134-44; Burleigh, *Death and Deliverance, supra* at 132-33.

Overall, it is estimated that 5,000 were provided a "mercy" death in the child operation, 80,000 to 100,000 in the adult T-4 program, 20,000 concentration camp inmates in the 14f13 project; "special treatment" against Jews in hospitals

eliminated another 1,000. Friedlander, *The Origins of Nazi Genocide, supra* at 150; Lifton, *The Nazi Doctors, supra* at 142. Some estimate the total toll of physician-assisted death was 275,000. Alexander, *Medical Science Under Dictatorship, supra*, 241 New Eng. J. Med. at 45-46. Other estimates reach as high as 400,000, from the child euthanasia, T-4, *Sonderbehandlung*, and 14f13 operations combined. Lifton, *The Nazi Doctors, supra* at 142. The true number of lives lost can never be known.[18]

III. TESTIMONY FROM THE TRIALS OF MEDICAL KILLINGS IN GERMANY PROVES THE NECESSITY OF AN ABSOLUTE PROHIBITION AGAINST KILLING BY PHYSICIANS.

Perhaps the best evidence for concluding that society must refrain from permitting any degree of killing by physicians is the testimony of those who participated in these crimes, as well as those who investigated and prosecuted them.

German physicians and other health care workers were put on trial for murder, crimes against humanity, and war crimes for their participation in the child euthanasia, T-4, 14f13, and "special treatment" projects.[19] Throughout these trials, the

[18] On January 20, 1942, nearly four years after the euthanasia program for Germans began with the *Gnadentod* of the Knauer child, the plans for the Final Solution of the "Jewish Problem" were completed at the Wannsee Conference, a meeting of thirteen high-ranking government officials. Proctor, *Racial Hygiene, supra* at 210; Lifton, *The Nazi Doctors, supra* at 158. But even then, "during early 1942, the details of the killing procedure were not yet clear, and were not solved until spring with the establishment of gas chamber camps in Poland." Lifton, *The Nazi Doctors, supra* at 158.

[19] Prof. Friedlander reports that

> a massive documentary record substantiate[s] the nature of these crimes. In addition to the Allied, German, and Austrian trials of the late 1940s, the German judiciary had conducted numerous detailed investigations and long trials during the 1960s and 1970s.

defendants insisted that their actions were motivated by compassion and humanitarian concerns. Valentin Faltlhauser insisted that, for him, "the decisive motive was compassion." Burleigh, *Death and Deliverance, supra* at 277. Pediatrician Ernst Wentzler recalled, "I had the feeling that my activity was something positive, and that I had made a small contribution to human progress." *Id.* at 100.

Also prevalent was the sentiment that, as physicians, these defendants' actions ought not be scrutinized by lawyers and judges. Dr. Hermann Pfannmüller, medical director at the Elgfing-Haar asylum hospital, complained at his trial before the Nuremberg Tribunal: "I am a doctor confronted with a lawyer and our points of view are completely divergent." Burleigh, *Death and Deliverance, supra* at 273.

Dr. Karl Brandt, who had played a critical role in the original authorization of the euthanasia program, spoke most directly in defense of its legitimacy, arguing through his attorney it was within the authority of the state to institute such a program. Nurem. Mil. Trib. II:135. In the closing argument for his case, Brandt made the following personal statement:

> Do you think that it was a pleasure for me to receive the order to permit euthanasia? For fifteen years I had toiled at the sickbed and every patient was to me like a brother. I worried about every sick child as if it had been my own. . . . I fully realize the problem; it is as old as mankind, but it is not a crime against man nor humanity. It is pity for the incurable, literally. Here I cannot believe like a clergyman or think as a jurist. I am a doctor and I see the law of nature as being the law of reason. In my heart there is a love of mankind, and so it is in my conscience. That is why I

Friedlander, *The Origins of Nazi Genocide, supra* at Preface *xi*. For a listing of over sixty various post-war German court cases and prosecutions for murder for participation in the euthanasia programs, see Friedlander, *The Origins of Nazi Genocide, supra* at 387-89.

> am a doctor! . . . Death can mean deliverance. Death is life—just as much as birth. It was never meant to be murder.

Nurem. Mil. Trib. II:139.

Similar arguments were put forth by Alfons Klein and other defendants at the Hadamar trial. Klein insisted that it was only in extreme cases, such as those involving the final stages of tuberculosis, that patients were "helped along" and saved from an insufferable prolonged death. "Only those people died who were very close to death already." *The Hadamar Trial, supra* at 88.

> One must therefore, in judging the facts, differentiate whether healthy, valuable lives were left to die, or whether those who had death stare into their face were given an injection of mercy to relieve them of their incurable and painful suffering. . . . I can say that the people were very ill and were saved from their suffering.

Id. at 102-03. Other Hadamar defendants justified the killings as acts of "mercy" and "deliverance." Burleigh, *Death and Deliverance, supra* at 152, 160.

The War Crimes tribunals invariably rejected these defenses. Nevertheless, they are indicative of the attitude that the defendants brought to their work in asylums and hospitals, an attitude which some specifically attributed to Hoche and Binding, and others to the general current of thought in German society. The attitude was shared by those who escaped punishment after the War. For example, Dr. Werner Catel, a "referee" in the T-4 program, later published a book advocating the "mercy killing" of severely defective infants. Burleigh, *Death and Deliverance, supra* at 284-285. In the last of the major euthanasia trials, in 1986, the defendants repeated the refrain that they had killed "out of love and pity." *Id.* at 289. These latter-day restatements of the (failed) defenses offered by defendants of 40 years earlier suggests a level of

sincerity inconsistent with the theory that these attempted justifications had been manufactured after the fact out of mere expediency. The perpetrators believed in the notion of "life unworthy of living" before, during, and after their horrendous crimes.

Those who investigated and prosecuted these crimes accepted the fact that these physicians had been corrupted, not merely by Nazi ideology, but first by acceptance of a fundamental change in attitude regarding the role of the physician toward the chronically sick.

U.S. Brigadier General Telford Taylor, chief of counsel for the prosecution, described the prominent physicians who were tried and convicted of murder:

> The defendants . . . are charged with murder, tortures and other atrocities committed in the name of medical science. . . .[They] did not kill in hot blood, nor for personal enrichment . . . they are not all perverts. They are not ignorant men. Most of them are trained physicians and some of them are distinguished scientists. The perverse thoughts and distorted concepts which brought about these savageries are not dead. They cannot be killed by force of arms. They must not become a spreading cancer in the breast of humanity. They must be cut out and exposed.

Nurem. Mil. Trib. I:66-71.

Dr. Leo Alexander noted the origin and persistence of such ideas in the wake of his experience as a medical expert at the Nuremberg medical trials:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude,

basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.

Alexander, *supra*, 241 New Eng. J. Med . at 44.[20]

Justice Robert Jackson, Chief of Counsel for the United States at Nuremberg Trial of Major German War Criminals, also observed the corruptive influence of accepting medical killing even in so-called "hard" cases:

> To begin with, [the Hadamar euthanasia program] involved only the incurably sick, insane and mentally deficient patients of the Institution. It was easy to see that they were a substantial burden to society, and life was probably of little comfort to them. It is not difficult to see how, religious scruples apart, a policy of easing such persons out of the world by a completely painless method could appeal to a hard-pressed and unsentimental people. But "euthanasia" taught the art of killing and accustomed those who directed and those who administered the death injections to the taking of human life. Once any scruples and inhibitions about killing were overcome and the custom was established, there followed naturally an indifference as to what lives were taken. Perhaps also those who become involved in any killings are not to be in a good position to decline further requests. If one is convinced that a person should be put out of the way because, from no fault of his own, he has ceased to be a social asset, it is not hard to satisfy the conscience that those who are wilful enemies of the prevailing social order have no better right to exist. And so Hadamar drifted from a hospital to a human slaughterhouse.

---

[20] In the last year of his life, Dr. Alexander drew explicit links between the German experience he had studied so extensively and the advocacy for legalized euthanasia in the United States: "It is much like Germany in the Twenties and Thirties. The barriers against killing are coming down." Patrick G. Derr, "The Real Brophy Issue," *Boston Globe* 15 (Nov. 18, 1985).

Forward to *The Hadamar Trial, supra* at *xiv.*

In conclusion, Justice Jackson issued a warning that should not be lost in the midst of arguments that American medicine would not be corrupted by the legalization of physician-assisted suicide:

> A freedom-loving people will find in the records of the war crimes trials instruction as to the roads which lead to such a regime and the subtle first steps that must be avoided.

Id.

CONCLUSION

Frustrated with the ethic of "preserving every existence, no matter how worthless," Dr. Alfred Hoche in 1920 wrote, expectantly: "A new age will arrive—operating with a higher morality and with great sacrifice—which will actually give up the requirements of an exaggerated humanism and overvaluation of mere existence." 8 Issues in Law & Med. at 265. Euthanasia proponents of our day, too, seek with great zeal to usher in a new age. They speak, in words echoing from a distant age, that it is cruel to deprive those who are suffering from their desired means to peace and freedom from pain. Like Binding, they scold: "Not granting release by gentle death to the incurable who long for it: this is no longer sympathy, but rather its opposite." *Id.* at 254.

The early promoters of euthanasia appeared to be sincere in their belief in the virtues of merciful death. Today's promoters of physician-assisted suicide may also be sincere, but it is a sincerity born of an unpardonable carelessness. Unlike their predecessors, euthanasia proponents today have the benefit of the lesson of history, which has taught the true nature of physician-assisted killing as a false compassion and a perversion of mercy. History warns that the institution of assisted-death gravely threatens to undermine the foundational ethic of

the medical profession and the paramount principle of the equal dignity and inherent worth of every human person.

The decisions of the Second Circuit and the Ninth Circuit should be reversed, and the complaints dismissed.

Respectfully submitted,

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Respondents.

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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

INTEREST OF THE AMICUS CURIAE

Agudath Israel of America, a national grassroots Orthodox Jewish movement founded in 1922, is deeply concerned about the rulings below and the broader

implications they hold for the future, and respectfully submits this brief as *amicus curiae* in support of the respective petitioners.

Informed by classical Jewish tradition which teaches that all human life is sacred, and possessed of the firm view that laws and judicial rulings that undermine the sanctity of human life send a message that is profoundly dangerous for all of society, Agudath Israel speaks out frequently, in a variety of legal and policy settings, on a broad array of issues that arise at the onset and conclusion of the human life cycle. In this court, for example, Agudath Israel has submitted briefs as *amicus curiae* in the abortion rights cases of *Webster* v. *Reproductive Health Services* (decision reported at 492 U.S. 490 (1989)) and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey* (decision reported at 505 U.S. 833 (1992)); and -- more directly relevant to the issues involved in the instant case -- in the "right to die" case of *Cruzan* v. *Director, Missouri Department of Health* (decision reported at 497 U.S. 261 (1990)).

Agudath Israel's interest in the issue of physician assisted suicide is especially keen. It is a basic principle of Jewish law and ethics that "[m]an does not possess absolute title to his life or body." J.D. Bleich, *The Quinlan Case: A Jewish Perspective*, reprinted in *Jewish Bioethics* 266, 270 (Hebrew Publishing Co. 1979). Agudath Israel believes that recognition of that teaching, as expressed in the historical disapprobation of suicide and euthanasia, has served as one of the pillars of civilized societies throughout

the generations. That pillar is now in peril.*

It is yet another principle of Jewish law and ethics that a doctor's role is to provide healing, not to hasten death. *See* I. Jakobovits, *Regarding the Law Whether it is Permitted to Hasten the End of a Terminal Patient in Great Pain*, 31 *Ha-pardes* 29 (1956). Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own Hippocratic mandate and undermine public confidence in the medical profession. Anthropologist Margaret Mead -- herself a supporter of certain forms of euthanasia, so long as they are under lay initiative and control -- has urged that "the medical profession should not be compromised by participation" in euthanasia; "[t]he physician's dedication to the saving of life is of incalculable value to humanity and must be protected from repeated efforts to involve the doctor in lethal activities." M. Mead, *From Black and White Magic to Modern Medicine*, 22 Proceedings of the Rudolf Virchow Medical Society 131 (1965). Agudath Israel views with considerable alarm the transformation of the physician's calling envisioned by the decisions below.

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* To the extent the Ninth Circuit below meant to suggest that Judaism "views suicide with equanimity or acceptance," *Compassion in Dying* v. *Washington*, 79 F.3d 790, 807 n.24 (1996) (*see also id.* at 808 n.25), the court was simply wrong. The general rule is that suicide and its facilitation are strictly forbidden under Jewish law, no matter how unbearable life may have become. *See generally* F. Rosner, *Modern Medicine and Jewish Ethics*, 225-39 (Ktav Publishing House, Yeshiva University Press 1986).

Moreover, as representatives of a people whose numbers were decimated little more than half-a-century ago by a society that "progressed" from its "enlightened" practices of "mercy killing" to the mass slaughter of millions of human beings deemed physically or racially "inferior," Agudath Israel is particularly sensitive to the legal assignment of diminished levels of life protection based on diminished levels of life "quality". The decisions below reflect this dangerous trend away from the recognition of life's inherent sanctity and present a stark challenge to our nation's social morals.

Agudath Israel submits this brief upon the consent of all parties.

ARGUMENT

The two federal circuit courts below -- the Ninth Circuit in *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir., March 6, 1996) (*en banc*), *request for rehearing denied,* 85 F.3d 1440 (9th Cir. June 12, 1996); and the Second Circuit in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir., April 2, 1996) -- found as-applied constitutional infirmities in Washington and New York state statutes that make it a crime to "aid" another individual in committing or attempting to commit suicide. The two rulings reached similar (though not identical) bottom lines, but arrived at their destinations through different constitutional routes.

The Ninth Circuit found a due process "liberty interest in choosing the time and manner of one's death," 79 F.3d at 798; and determined, in the context of "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors," that such due process liberty interest outweighed any countervailing interest asserted by the state. *Id.* at 838.

The Second Circuit, in contrast, relied on the equal protection clause in holding that physicians are constitutionally permitted to "prescribe drugs to be self-administered by mentally competent adults who seek to end their lives during the final stages of a terminal illness." 80 F.3d at 718. Such persons, reasoned the court, are "similarly circumstanced" to final-stage terminally ill patients who enjoy the statutory and common law right to hasten their death by authorizing termination of life support, *id.* at 729; and, the court concluded, there is no legitimate state interest rationally served by distinguishing between the two categories. *Id.* at 730-31.

Both grounds of decision, Agudath Israel submits, are wrong. The better of the legal argument, we believe, is with the dissenting judges in the Ninth Circuit *en banc* decision (79 F.3d at 839 (Beezer, J.), 857 (Fernandez, J.) & 857 (Kleinfeld, J.)); with the dissenting judges in the Ninth Circuit's subsequent rejection of a request to have the *en banc* decision reheard by the full circuit court (85 F.3d at 1440 (O'Scannlain, J.), 1446 (Trott, J.)); with the Ninth Circuit's earlier panel in *Compassion in Dying* v. *State of Washington*, 49 F.3d 585 (9th Cir. 1995); with the district court in *Quill* v. *Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994); and with the Michigan Supreme Court in *People* v. *Kevorkian*, 447 Mich. 436 (1994), *cert. denied* 115 S. Ct. 1795 (1995). With respect to the due process argument, we share the view of these judges and courts that this Court's broad dictum in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 851 (1992) -- identifying "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" as being "at the heart of liberty" -- does not elevate assisted suicide to the status of a constitutionally protected right. With respect to the equal protection argument, we contend, as have many courts, legislative and executive bodies, medical associations and bioethical experts, that there is a sound basis of legal distinction between what one commentator has termed "letting the patient die" and "making the patient die" S.L. Carter, *The Culture of Disbelief* 236 (Basic Books 1993) -- though we also believe there can and should be legal restrictions on the authority of patients and their surrogates even to decline life support.

Mindful of the admonition that "[a]n *amicus* brief which does not serve [the purpose of bringing relevant

matter to the attention of the Court that has not already been brought to its attention by the parties] simply burdens the staff and facilities of the Court and its filing is not favored," Rule 37.1, *Rules of the Supreme Court of the United States* (1990), we will not belabor the reasons we think the constitution does not create any right to assisted suicide; they are well articulated in the decisions and opinions cited in the preceding paragraph, and are sure to be further developed by the petitioners themselves.

The focus of our argument, therefore, will be not on why we think the decisions below are *bad* law, but why we think they are *dangerous* law. The legalization of assisted suicide, even in the narrow contexts addressed by the decisions below, has the potential to lead to tragic abuse (Point I, *infra)*. Moreover, the Ninth and Second Circuit rulings portend a far-reaching relaxation of laws against assisted suicide and euthanasia, in contexts very different than those in which the two cases arose (Point II, *infra*). Perhaps most troubling, the two courts' determination that lives of diminished "quality" are entitled to diminished constitutional protection ignores some important lessons of 20th century history that deserve careful consideration (Point III, *infra)*.

I.

LEGALIZING ASSISTED SUICIDE, IN ANY FORM, COULD LEAD TO TRAGIC ABUSE

Agudath Israel takes both moral and legal exception to the notion that a person enjoys unfettered personal autonomy to decide that his life is no longer worth living. Society has the right to compel citizens to submit to

vaccination, *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905); to insist that a child receive life-sustaining treatment even over the religiously motivated opposition of his parents, *Jeovahs Witnesses* v. *King County Hospital Unit*, 390 U.S. 598 (1968); to prevent a pregnant woman in her second trimester from receiving an abortion in an unlicensed facility, *Roe* v. *Wade*, 410 U.S. 113, 163 (1973); to restrict the handling of poisonous snakes and drinking poisonous substances as part of a religious ceremony, *State ex rel. Swann* v. *Pack*, 527 S.W. 2d 99 (Tenn. 1975), *cert denied* 424 U.S. 954 (1976); to enact laws designed to protect users of highways "even against the consequences of their own action," *Bisenius* v. *Karns*, 165 N.W. 2d 377, 382, *appeal dismissed* 365 U.S. 709 (1969).

There are particularly strong reasons to reject the view that the generally accepted doctrine of personal autonomy in medical decision making should allow patients to enlist their doctors' help in committing suicide. The potential abuses of legalizing assisted suicide have been well catalogued by a host of legal and medical observers. For example, in its landmark report opposing assisted suicide, the 24-member New York State Task Force on Life and the Law, speaking unanimously, noted the following concerns: the pressures patients would feel, from their doctors and families, to opt for suicide; the inherent inequalities of our health care delivery systems which tend to discriminate against the poor, the handicapped and the elderly; the psychological vulnerability of the severely ill; the risk of misdiagnosis of the patient's condition; the likelihood in many cases that adequate treatment of pain and depression would dissuade the patient from seeking death. New York State Task Force on Life and the Law, *When Death is*

Sought: Assisted Suicide and Euthanasia in the Medical Context 121-34 (1994). Indeed, these risk factors will often raise serious doubts about whether a patient's request for help in committing suicide is truly an expression of the patient's autonomous will.

We concur with the Task Force's observation (Report at 121) that, "as a society, we have better ways to give people greater control and relief from suffering than by making it easier for patients to commit suicide or to obtain a lethal injection."

II.

THE DECISIONS BELOW, IF AFFIRMED, ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA

On their faces, the Ninth and Second Circuit decisions are extremely narrow. They apply only to fully competent terminally ill patients (or, in the case of *Quill*, patients in the "final stages" of terminal illness) who have clearly expressed their desire to commit suicide, and who seek only such assistance from their physicians as is necessary for them to self-administer a lethal dosage of drugs. However, the *language* of the decisions (especially the expansive statements of the Ninth Circuit), and their *reasoning* (especially the equal protection analysis of the Second Circuit), could well result in the expansion of the right to assisted suicide and euthanasia far beyond the narrow confines in which the cases arose. The Court would do well to ponder the ultimate destination of the paths the Ninth and Second Circuits would have the constitution embark.

1. The Ninth Circuit's Candid Acknowledgments

The three patient-plaintiffs in *Compassion in Dying* (in this Court as *Glucksberg*) were mentally competent, whose illnesses were deemed "terminal" because their doctors had concluded they were irreversible and would likely cause death within a relatively short time, and who clearly articulated their desire to have their doctors furnish them with a lethal dosage of medication for their own self-administration. The Ninth Circuit, however, candidly acknowledged that its ruling in their favor was not so narrowly limited.

For one thing, said the court, it is not only doctors whose prescriptive services are protected by the constitutional right to assisted suicide, but also "those whose services are essential to help the terminally ill patient obtain and take [the lethal prescription] and who act under the supervision or direction of a physician... That includes the pharmacist who fills the prescription; the health care worker who facilitates the process; the family member or loved one who opens the bottle, places the pills in the patient's hand, advises him how many pills to take, and provides the necessary tea, water or other liquids; or the persons who help the patient to his death bed and provide the love and comfort so essential to a peaceful death." 79 F.3d at 838 n.140. In addition, the court noted that its holding encompassed the decisions of persons who are terminally ill not only as that term is colloquially understood, but also as it is statutorily defined -- in Washington Sate, for example, persons who are in an irreversible coma or a persistent vegetative state, regardless of their life expectancy. 79 F.3d at 831.

Significant though these acknowledgements are, it is in two other respects that the Ninth Circuit's expansive articulation of its position is especially noteworthy: (a) the court's view on physician-administered poison; and (b) the court's recognition of the authority of surrogate decision makers.

(a) While the court expressly left for "future cases" the issue of a doctor's right to inject a lethal dosage into a patient incapable of self-administering the poison, it candidly indicated its view that this too would be constitutionally protected:

> "We do not dispute the dissent's contention that the prescription of lethal medication by physicians for use by terminally ill patients who wish to die does not constitute a clear point of demarcation between permissible and impermissible medical conduct. We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them... We would be less than candid... if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. In the first case — volitional death — the physician is aiding or assisting a patient who

> wishes to exercise a liberty interest, and in the other — involuntary death — another person acting on his own behalf, or, in some instances society's, is determining that an individual's life should no longer continue. We consider it less important who administers the medication than who determines the medication than who determines whether the terminally ill person's life shall end." 79 F.3d at 831-32 (footnotes omitted).

(b) The court emphasized that the constitutional demarcation it would draw between "volitional death" and "involuntary death" was not intended to imply that the right to request assistance in committing suicide is necessarily personal to the patient himself. "[W]e should make it clear," wrote the court, "that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." 79 F.3d at 832 n.120. (Indeed, noted the court, under certain circumstances, Washington law also regards the decisions of a legal guardian as the decision of the patient himself, 79 F.3d at 818 (citing, *inter alia*, *In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), in which the Washington Supreme Court authorized a legal guardian to "make a good-faith determination of whether the withholding of life sustaining treatment would serve the incompetent patient's best interests" where the patient's own wishes cannot be ascertained, 747 P.2d at 457). Presumably, therefore, just as a duly appointed surrogate decision maker could request a lethal prescription on a patient's behalf, so too could a legal guardian in cases where his decisions are treated as the patient's own.)

It should be readily apparent that the Ninth Circuit's

caveat about the authority of surrogate decision makers undermines considerably its bright line distinction between "volitional death" and "involuntary death". Professor Tribe has summarized the three types of situations in which surrogate decision makers have exercised "substituted judgment" on behalf of incompetent patients:

> "There are basically three approaches courts have taken to decisionmaking in treatment decisions for incompetent patients. First, if the patient had when competent stated what decision she would have wanted made in this situation, those wishes tend to be deemed decisive. Second, where there is no direct evidence of the patient's preferences, if there is a relative or a friend who was close enough to the patient to be able to surmise how she would have decided, this relative or friend may be allowed to choose in the name of the patient. Third, if there is no basis for deciding what the patient would have decided, a decision is made according to what would be in the patient's 'best interests', as defined by the court, by the patient's family, or by a court-appointed guardian."

L. Tribe, *American Constitutional Law*, § 15-11 at 1368-69 (2d Ed. 1988) (footnotes omitted). As Professor Tribe points out, however, "*[a]ll three forms of 'substituted judgment' are at best imperfect ways to effectuate the patient's right of self-determination*. No matter how much evidence there is of subjective intent, how well the guardian knew the patient, and how well-intentioned the patient's guardian, family, and physician may be, *there will always*

be some residual doubt that the decision made in fact expresses what the patient would have wanted done." Id. at 1369 (emphasis added; footnote omitted).

In sum, the Ninth Circuit would apparently extend the constitutional right of assisted suicide to cases involving a surrogate decision maker's request, based on his admittedly imperfect knowledge of an incapacitated terminal patient's wishes, or perhaps even on his own assessment of the patient's best interests, to have a doctor *kill the patient*. This brings to mind a prescient passage elsewhere in Professor Tribe's treatise:

> "As courts become more sympathetic to arguments that persons have a right to die with dignity and that the state interest in the preservation of life may sometimes be subordinated to an individual's right to die, there is a possibility that doctrines which are intended to facilitate the exercise of this right will be exploited, either intentionally or unwittingly, to practice the most terrible discrimination against handicapped persons who require medical treatment to stay alive: judgments that their disabilities are such that persons afflicted with them would be better off dead and thus should be 'allowed' to die. The most pernicious discriminatory bias against the disabled that one can imagine -- the desire of families or others to dispose of handicapped persons whom they simply consider undesirable -- might be effectively disguised behind their requests, made in the name of the disabled's right to die, that

> medical treatment be withheld from the disabled. The right to die, in other words, may offer a convenient pretext for profoundly discriminatory decisionmaking."

L. Tribe, *supra,* § 16-31 at 1598-99 (footnotes omitted).

2. Implications of the Second Circuit's Equal Protection Analysis

The Second Circuit took pains to give its ruling a more moderate veneer than that of its sister court. The court expressly rejected any substantive due process right to assisted suicide, 80 F.3d at 723-25; determined that the equal protection claim would be judged under the less exacting standard of rational basis scrutiny, *id.* at 727; intimated that the right to assisted suicide would not authorize a physician to inject a lethal dosage into a patient incapable of self-administering the dosage, *id* at 730 n.3; said nothing about the right of a surrogate decision maker to request suicide assistance on behalf of an incapacitated patient; and limited the terms of its holding to patients in the final stages of terminal illness, *id.* at 731.

In fact, however, it may well be that the Second Circuit's ruling creates an even more expansive right to assisted suicide than does the Ninth Circuit's. That is because of a basic difference between the respective judicial inquiries under the due process and equal protection clauses.

As the Ninth Circuit pointed out, the due process constitutional claim of a patient seeking suicide assistance will be determined, like all substantive due process claims,

by weighing the strength of the various competing interests present in any given circumstance. The court's calibration of those competing interests led it to its bottom line determination: "The liberty interest at issue here...in the case of the terminally ill, is at its peak. Conversely, the state interests, while equally important in the abstract, are for the most part at a low point here." 79 F.3d at 837. While Agudath Israel believes, as elaborated *infra,* that the Ninth Circuit incorrectly undervalued the state's interest in preserving the life of even terminally ill persons there is at least some room for argument that the due process balancing framework will enable courts, in cases involving non-terminal patients where the balance of competing interests tips in favor of the state, to draw the line: "So far down the slope, but no farther." The equal protection framework embraced by the Second Circuit, in contrast, would appear to include no such line-drawing braking mechanism.

The relevant equal protection inquiry here is *not* how strong the state's interest is in preserving life in any given context, but whether treating "similarly circumstanced" persons differently is rationally related to a legitimate state interest. As the Court stated in *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612 (1985): "When a state distributes benefits unequally, *the distinctions it makes* are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if *the distinction* rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted; emphasis added). Accordingly, once one accepts the Second Circuit's conclusion that a patient who seeks termination of life support and a patient who seeks poison are "similarly circumstanced persons" who must be treated identically

unless the state can demonstrate that treating them differently rationally advances a legitimate state interest, 80 F.3d at 729; and once one accepts the court's additional conclusion that no such rational basis of distinction exists when the two persons are in the final stages of terminal illness, *id.* at 730-31 -- there is no readily apparent logical way of drawing lines anywhere along the slope.

In reaching its holding that the prohibition against assisted suicide, as applied to final-stage terminally ill patients, violates the equal protection clause, the Second Circuit posed a series of dramatic questions, and an equally dramatic answer:

> "But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes... And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life' [citation omitted], when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'" 80 F.3d at 729-30.

The questions are indeed dramatic, and so is the response -- but they are also highly misleading. For they imply that the equal protection analysis would be different in cases where the state's interest in preserving life would

be stronger than the Second Circuit deems it to be at the final stages of terminal illness. In fact, however, since the relevant inquiry is not whether the state has a rational basis to preserve life, but whether it has a rational basis to *distinguish* between patients who refuse life support and patients who seek the means to commit suicide, it should make no equal protection difference whatsoever how far along the patient's terminal illness has progressed, or even whether he is terminally ill altogether. The strength of the state's interest in preserving life is simply not relevant to the equal protection inquiry, for it does not speak to any distinction the law might draw between the two patients "similarly circumstanced."

The implication of the Second Circuit's ruling, therefore, is that *wherever* the law permits an individual to forgo life support, equal protection demands that it also permit him to request a lethal prescription. The Second Circuit's apparent moderation is only skin deep; beneath its deceptively mild surface lies constitutional radicalism.

Consider the body of New York law implicated most directly by the ruling below. The right of competent persons to decline or discontinue life-sustaining medical intervention was first established at common law in *Schloendorf* v. *Society of New York Hospital*, 211 N.Y. 125, 129 (1914), where Judge Cardozo enunciated the basic doctrine of personal autonomy in medical decision-making: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *In re Storar*, 52 N.Y. 363, 376-77, *cert. denied*, 454 U.S. 858 (1981), makes clear that the common

law right of personal autonomy includes the right to refuse treatment necessary to preserve one's life. The New York courts have not limited such right to patients who are terminally ill -- certainly not to patients who are in the final stages of their terminal illness. Given the Second Circuit's rejection of any distinction between refusing life support and requesting poison, if a young patient with a good prognosis for recovery enjoys the common law right to refuse a life-saving operation, should he not also enjoy the right to a lethal prescription?

The same question will apply when a third party is legally authorized to make a decision on an incapacitated patient's behalf. Under New York common law, "the right to decline treatment is personal and...could not be exercised by a third party when the patient is unable to do so" unless there is "clear and convincing evidence" that the incapacitated patient would have refused life support. *Matter of Westchester County Medical Center*, 72 N.Y. 2d 517, 528-29 (1988). New York's legislature, however, has started moving away from the "clear and convincing evidence" standard. Most notably, in 1990, a statute was enacted empowering a duly designated health care agent to make virtually any life-and-death treatment decision on behalf of his incapacitated principal, irrespective of the principal's medical condition or prognosis. Such decisions are to be made on the basis of the principal's wishes; or, where the principal's wishes "are not reasonably known and cannot with reasonable diligence be ascertained," on the basis of the principal's "best interests." N.Y. Public Health Law § 2982 (McKinney's 1993). Indeed, the state legislature has been considering proposed new legislation developed by the New York State Task Force on Life and the Law, introduced in the 1995-96 legislative session as S.

5020 / A.6791, which would empower surrogates -- third parties appointed by the *law*, not by the *patient* -- to make decisions under certain medical circumstances to refuse life-sustaining treatment where the patient's "best interests" would be so served. The Second Circuit's equal protection analysis, it would seem, should empower such agents or third party surrogates to ask that the patient be provided with poison as well, so long as they deem it to be in the patient's "best interests."

There is yet one other noteworthy aspect of New York law: the legal obligation of an individual health care provider to carry out the instructions of patients and their duly appointed health care agents; or, if doing so would violate the provider's religious beliefs or sincerely held moral convictions, to cooperate in facilitating transfer of the patient to another medical practitioner who is prepared to carry out such wishes. N.Y. Public Health Law § 2984 (McKinney's 1993). If a doctor has religious beliefs or moral convictions that preclude him from helping the patient commit suicide, would not the Second Circuit's equal protection analysis require his cooperation in transferring the patient to a doctor who has no such qualms?

New York is not atypical in its recognition of a patient's right to decline life-sustaining interventions, either personally or through an agent or surrogate; if anything, New York's common law takes a harder line than most other states in insisting on clear and convincing evidence of an incapacitated patient's wishes. See *Cruzan* v. *Director, Missouri Dept. of Health*, *supra*, 497 U.S. at 270-77. If the Second Circuit's ruling is permitted to stand, its impact will be widespread, profound -- and, in our view, devastating.

III.

ASSIGNING DIMINISHED LEGAL PROTECTION TO A LIFE OF DIMINISHED MEDICAL QUALITY FOLLOWS DANGEROUS HISTORICAL PRECEDENT

In evaluating the state's interest in preserving and protecting a person's life, the Ninth Circuit determined that the strength of the interest depends, in part, on the person's medical condition; when the person is terminally ill and wants to die, the strength of the state interest is low. 79 F.3d at 837. Similarly, the Second Circuit concluded -- unnecessarily for its equal protection analysis, as elaborated *supra* -- that the state's interest in preserving life "lessens as the potential for life diminishes." 80 F.3d at 729. In so doing, the courts below all but nullified this Court's observation that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan*, *supra*, 497 U.S. at 282.

Historical precedent confirms the wisdom of allowing society to treat human life, whatever its medical "quality", as an inherent good that deserves state protection. One need look no further than the contemporary example of the Netherlands, where many physicians have apparently engaged in nonvoluntary euthanasia despite that nation's limited authorization of only voluntary euthanasia. The New York State Task Force on Life and the Law described this "abuse" as "an inevitable byproduct of the transition from policy to practice" of permitting the taking of human life "as a 'therapeutic' alternative." *When Death Is Sought*, *supra*, at 133-34.

The history of the German euthanasia program earlier this century, under which some 200,000 mentally ill or physically disabled people were put to death by German doctors, *see generally* M. Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-45* (Cambridge Press 1994), also bears consideration. Burleigh cites Binding and Hoche's 1920 tract *Permission for the Destruction of Life Unworthy of Life* -- "by far the most influential contribution to the debate on euthanasia" -- as being premised on "the idea that every individual had sovereign powers to dispose of his or her own life as he or she saw fit; specifically to commit suicide." Upon that foundation the authors constructed a model that would lead to widespread medical killing in the name of mercy and social utilitarianism. *Death and Deliverance, supra* at 15-17.

In 1949, Dr. Leo Alexander, chief medical consultant to the prosecution at the Nuremberg War Crimes Tribunal, offered this trenchantly chilling analysis of the origins of the euthanasia program in Germany:

> "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass

> the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."

Alexander, *Medical Science Under Dictatorship*, 241, New England Journal of Medicine 40, 46 (1949). Dr. Alexander sounded a warning to his fellow Americans:

> "American physicians are still far from the point of thinking of killing centers, but they have arrived at a danger point of thinking, at which likelihood of full rehabilitation is considered a factor that should determine the amount of time, effort and cost to be devoted to a particular type of patient....Americans should remember that the enormity of a euthanasia movement is present in their own midst." *Id.*

We do not mean to suggest that constitutionalizing a right to assisted suicide is likely to lead to the type of moral collapse that occurred in the German medical profession earlier this century. As two commentators have noted, however, we dare not ignore the lessons of that dark era:

> "We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive.' The 'angel of mercy' can become the fanatic, bringing the 'comfort' of death to some who do not

> clearly want it, then to others who 'would really be better off dead,' and finally, to classes of 'undesirable persons,' which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged. . . . In the current environment, it may well prove convenient - and all too easy - to move from recognition of an individual's 'right to die' (to us, an unfortunate phrasing in the first instance) to a climate enforcing a 'duty to die.'"

Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?*, 145 Archives of Internal Medicine 130-31 (1985). Yet another commentator issued this bleak observation:

> 'What makes the administrative mass killings so outstanding is not their numbers, their efficiency, or their cruelty, but the fact that they occurred in an epoch when nobody thought it was humanly or socially possible. Therein lies their deepest lesson. If it was possible then, why not again? What has fundamentally changed? The curtain may have gone down -- but only for the intermission." F. Wertham, *The German Euthanasia Program* 31 (1980).

In the decisions below, we detect -- ever so faintly, ever so benignly, but ever so ominously -- the rustling of the curtain once again.

CONCLUSION

The constitution can be a powerful engine of social change -- for better, and for worse. As Agudath Israel sees it, the rulings of the Ninth and Second Circuits are examples of constitutionalism at its most dangerous.

For the reasons set forth in petitioners' briefs, and the additional reasons set forth herein, Agudath Israel of America respectfully urges the Court to reverse the rulings below and clarify the limits of constitutional moral revolution.

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writ Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF OF *AMICI CURIAE* CHRISTIAN LEGAL SOCIETY, CHRISTIAN MEDICAL AND DENTAL SOCIETY, CHRISTIAN PHARMACISTS FELLOWSHIP INTERNATIONAL, NURSES CHRISTIAN FELLOWSHIP, AND FELLOWSHIP OF CHRISTIAN PHYSICIAN ASSISTANTS IN SUPPORT OF PETITIONERS

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INTEREST OF THE *AMICI CURIAE*

The interest of each *amicus curiae* is set forth in the Appendix to this brief. The letters from the parties consenting to the filing of this brief have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

In the rush to divine a new constitutional right to physician-assisted suicide, the courts below failed to give adequate consideration to the consciences of the many health professionals who will be forced to participate in physician-assisted suicide. The decisions below will radically change the health care system into one in which health professionals routinely will be called upon to implement physician-assisted suicide. Many health professionals will find themselves coerced into some degree of involvement in the intentional killing of patients, including patients who are incompetent and not terminally ill.[1]

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[1] Importantly, the context of "physician-assisted suicide" is not limited to situations in which a competent, terminally ill patient makes his or her own decision to terminate his or her life and seeks from the health care professional "only" the means of doing so. As the Ninth Circuit made clear in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), its ruling would not be limited to situations in which the patients would self-administer the fatal drug dosage, but would extend as well to patients who are not terminally ill but in a persistent vegetative condition, as well as patients whose guardians make the decision to have a fatal drug dosage administered to the patient. *See, e.g.*, Wash.App. A99 (definition of terminal illness "includes persons who are permanently unconscious, that is in an irreversible coma or a persistent vegetative state"); A100-101 ("recogniz[ing] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them"

Amici include health care professionals who have substantial reason to believe that they will be subject to significant pressure from supervisors, insurance companies, employers (including managed care associations, nursing homes, and hospitals) to participate in the administration of fatal drug dosages to patients. *Amici* have religious convictions against enabling others to kill themselves, as well as against killing patients, whether or not the patient has consented to the killing.

Contrary to popular belief, individual physicians on staff at a hospital, health clinic, nursing home, or managed care organization often do not have sufficient autonomy to make medical decisions that carry significant economic costs for their employers. Employers who are concerned about a profitable bottom-line are unlikely to allow employee health professionals the requisite scope to obey their religious convictions, when the employers will be bearing the economic cost of the employees' inconvenient religious convictions. Part I briefly describes a sampling of realistic scenarios in which objecting physicians, medical students, nurses, pharmacists, and other health care professionals will find it virtually

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but denying that issue was being decided); *id.* n.120 ("Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.").

The court did not address specifically how one person choosing death for another is suicide or how a patient incompetent to make such a decision would be competent to administer the lethal dosage of medicine to herself. Clearly, when the patient cannot self-administer the fatal dosage, someone will be required to do so, and often that person will be the physician or nurse attending the patient.

For purposes of this brief, "Wash.App." will refer to the Appendix to Petition for Writ of Certiorari in *State of Washington v. Glucksberg*, No. 96-110, and "N.Y.App." will refer to the Appendix to Petition for Writ of Certiorari in *Vacco v. Quill*, No. 95-1858.

impossible to avoid participation in physician-assisted suicide. For example, physicians likely will be required to justify, to their employers or insurance companies, a decision not to provide fatal drug dosages to terminally ill patients. Physicians will be asked to provide suicide assistance to patients unable to make such a decision for themselves but whose legal guardian desires a fatal dosage to be administered.

Nor will physician-assisted suicide affect only the patient and doctor. A nurse is likely to be the agent required to administer the fatal dosages, just as he or she is the person who administers most medications to patients in hospitals, clinics, and nursing homes. The ordering physician is unlikely to be sensitive to a nurse's failure to "carry out orders," particularly when the physician is likely to perceive the nurse's refusal as an implicit condemnation of the physician's own morality.

In medical school or residency, medical students may be required to learn, using real patients, how to administer fatal dosages in the proper strength and manner. Medical facilities that refuse to provide such training may be threatened with a loss of accreditation.

The decisions below fail to recognize the legitimate concerns of numerous health professionals who are prohibited by religious convictions from intentionally killing another human being or assisting another person in committing suicide. One effect of the decisions below may be a further decrease in the availability of health care professionals, as many doctors and nurses are driven out of their chosen profession and many students forego medical careers, simply because they cannot participate in a health care system in which physician-assisted suicide is impossible to avoid in real-life terms.

Part II describes the fundamental legal errors in the decisions below. Both courts wrongly equated termination of life-sustaining medical treatment with the affirmative prescription of lethal medication. Yet the common law, numerous state laws, several judicial opinions, and leading medical authorities all recognize that there is a

critical distinction between a decision to stop treatment and a decision to administer deadly drug dosages.

In Part III, *amici* refute the Ninth Circuit's assertion that tradition and history support the right to assisted suicide. Contrary to the Ninth Circuit's interpretation of Biblical accounts of individuals committing suicide, there has been no acceptance of suicide as moral within the historical Christian tradition. Instead, the early Church condemned "self-murder." National and Washington State history also do not support a right to commit suicide.

ARGUMENT

I. Physician-Assisted Suicide Will Profoundly Affect the Ability to Obtain and Retain Employment for Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings.

A. Contrary to the decisions below, health care professionals with religious convictions against killing other persons will not be able to avoid the widespread effects on the health care system of physician-assisted suicide.

At its core, the practice of medicine is based on a relationship – the relationship between the patient and the physician. Both have a moral stance in the relationship, with external and internal pressures acting upon each. The discussion regarding physician-assisted suicide in the decisions below focused almost exclusively on the patient's desires, needs, or rights. However, even if a legitimate case could be made for the need of the patient to be assisted by a physician in committing suicide, it is still necessary to examine the interests and needs of the other party to the relationship – the physician.

Legalizing physician-assisted suicide is certain to affect physicians who object for religious reasons to the intentional termination of another human being's life. For

legal as well as economic reasons, physicians will find it increasingly difficult to refuse to assist patients in committing suicide. Once legalized, the practice of physician-assisted suicide will become the norm, the standard of care expected from a physician. It is likely that a positive duty to perform this "service," and assist patients to commit suicide, will be recognized and become a potential source of malpractice claims against physicians who refuse to perform physician-assisted suicides. Physicians with religious objections to killing oneself or other human beings will be forced either to aid directly in suicide or, at a minimum, to be an accomplice to the suicide by arranging referrals to physicians who are willing to participate. Under some forms of managed care organizations, physicians who refuse to assist a patient in killing himself are likely to be required to pay another physician's charges for killing the patient.

Scenario 1: Dr. Smith is a primary care physician working in a managed care organization. The organization uses a strict capitation model for care, in which patients initially see their primary physician for all complaints and are referred to a specialist only if the primary physician feels it is necessary. The physician must certify the need and authorize the funding for this care. The organization adopts this model of care in order to decrease expenditures for specialty care and realizes a profit only if actual expenditures are less than or equal to those planned for during the term of the contract with the physician. Physicians who repeatedly exceed their "caps" are unlikely to have their contracts renewed.

Dr. Smith evaluates a patient with AIDS, who is still likely to live a considerable length of time but who requests Dr. Smith's assistance in committing suicide now. Dr. Smith considers the likely expenses involved in providing care for this patient if the patient chooses maximal therapy over the next months and years, as opposed to the expenses incurred if the patient commits suicide within the month.

Recognizing that maximal therapy will greatly exceed the cap for this patient, Dr. Smith is nonetheless unable for religious reasons to participate in the suicide herself or to refer the patient to another physician. As a result of this decision, Dr. Smith is likely to face several crises involving coercion of conscience:

1) May her employer, the managed care organization, require her to refer the patient to a physician willing to help him commit suicide?

2) If Dr. Smith is bypassed and someone else in the managed care organization refers the patient to a physician who will assist him in committing suicide, may the employer, the managed care organization, require Dr. Smith to pay for the expenditure for the suicide procedure from her own account?

3) Given that the option for physician-assisted suicide is better financially for the managed care organization, may the organization require its employee Dr. Smith to inform all her HIV-positive patients about the option of physician-assisted suicide?[2]

4) Will Dr. Smith's "mix" of patients change, making her more likely to exceed her overall "cap," with the attending economic consequences for her practice and the likelihood that her contract with her employer will not be renewed?

5) May the managed care organization require Dr. Smith to inform all her patients, even those without lethal illnesses, of the option of physician-assisted suicide, in

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[2] Merely raising the option may suggest to a patient that " 'his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision.' " Chairman Charles T. Canady, Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess., *Physician-Assisted Suicide and Euthanasia in the Netherlands* 9 (Comm. Print 1996) (hereinafter "*Physician-Assisted Suicide* Report") (quoting testimony by hearing witness psychiatrist Dr. Herbert Hendin on the prevalence of doctors in the Netherlands who initiate the idea of euthanasia as a treatment option with their patients).

order for them to include the option in their advance written directives?

6) May Dr. Smith be required to record in a patient's records an advance written directive requesting physician-assisted suicide?[3]

Physician-assisted suicide will also harm nurses, medical students, pharmacists, and other health care providers with religious objections to the intentional killing of other human beings. As the following scenarios illustrate, "[n]urses and many other health care workers are particularly vulnerable to pressure because they occupy subordinate positions in the hospital/medical hierarchy." Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. Legal Med. 177, 220 (1993).

Scenario 2: Nurse Doe is the registered nurse responsible for the medical/surgical floor in a small community hospital. A patient on the floor, who is unable to move or feed himself, requests his physician's assistance in committing suicide. The physician agrees to the patient's request and writes in the patient's chart the order for the patient to be given a lethal dosage of medicine.

Due to her religious convictions, Nurse Doe is opposed to the intentional killing of another human being. Therefore, she informs the physician that she will not administer the lethal dosage of medicine to the patient that the physician has ordered. The physician angrily states that he will administer the drug himself. He

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[3] *Cf.*, The Federal Patient Self-Determination Act, 42 U.S.C.A. § 1395cc(f) (West 1992 & Supp. 1995) (requiring all health care providers receiving Medicaid or Medicare to inform patients about state laws regarding advance directives to refuse life-sustaining treatment and to record any advance directive of the patient). If the decisions below are affirmed, it is not difficult to anticipate that the federal government might require all physicians to record patients' advance directives regarding physician-assisted suicide.

orders Nurse Doe to open the controlled substance cabinet to which she has the key. Nurse Doe is unwilling to assist in the suicide at all.

Nurse Doe faces repercussions for her refusal to participate in the suicide, including:

1) May the physician file a complaint against her for refusing to carry out his orders?

2) May her supervisor take her refusal into consideration in her annual evaluation and in decisions regarding pay raises?

3) Must she abandon hospital nursing in order to avoid similar situations in the future as physician-assisted suicide becomes increasingly widespread?

This scenario is based on the Ninth Circuit's acknowledgment that "in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, *or a person acting under his direction or control*, may be the only way the patient may be able to receive them." Wash.App A100 (emphasis added).

The nurse's role in assisting patients to commit suicide is the subject of the highly instructive *Guidelines for Euthanasia*, promulgated by medical groups in the Netherlands, "in regard to cooperation and job demarcation of doctors/nurses and aids in procedures relating to euthanasia." Royal Netherlands Society for the Promotion of Medicine and Recovery, Interest Association of Nurses and Nursing Aids, *Guidelines for Euthanasia, reprinted in* 3 Issues in Law and Medicine 429 (1988) (Walter Lagerwey trans.). The Guidelines concede that euthanasia has engendered problems between nurses and physicians:

> Lack of clarity in respect to tasks, competences, and responsibilities of doctors on the one hand and nursing personnel and aids on the other, with regard to euthanasia, gives rise to conflicts and dissension in daily practice.

Id. at 429-430.

While claiming that "euthanasia, if it occurs, is performed by a doctor," *id.*, the Guidelines "realize that there

is a discrepancy between the content of these guidelines, in which it is posited that only a doctor shall be entrusted with the carrying out of euthanasia and *actual every day practice in which nursing attendants and aids are often directly involved in euthanasia activities.*" *Id.* at 435 (emphasis added).

The Guidelines recognize that nurses will often receive the initial request for euthanasia. *Id.* at 433. In cases where the doctor has decided to carry out euthanasia, "[i]f the nursing and caring attendant has [sic] doubts about the manner in which the standards of appropriate medical care are carried out," the Guidelines direct the nurse to talk to the doctor. If the nurse still "continues to have serious doubts after receiving information from the doctor," she may consult a second physician or seek the "mediation of the nursing head of the division or directors of the institution," but she must inform both the patient and the attending doctor before she does any of the above. *Id.* at 434-435.[4]

As the primary direct caregivers to patients, nurses necessarily will be the persons most affected by the implementation of assisted suicide in hospitals and nursing homes. They are also the persons least likely to have sufficient influence or authority to be able to avoid complicity in assisting patients to commit suicide. The decisions below will force many nurses into an untenable

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[4] The Guidelines provide that doctors and nurses who have conscientious objections to euthanasia may refuse to participate in the process. But they must also not participate in the *initial* decisionmaking process "because then there can be no question of an objective participation in the decision for euthanasia." *Id.* at 436. That is, an anti-euthanasia physician's participation in the euthanasia decisionmaking process biases the process, but participation by a pro-euthanasia physician does not. If a conscientious objector is the first person to hear the patient's request, "he is (morally) obligated to inform the patient of his view of euthanasia" and "give the patient the opportunity to contact another provider of assistance." *Id.*

position, forcing them either to violate their religious convictions against taking the life of another human being or to forfeit their jobs.

Scenario 3: Dr. Jones has been the physician attending the patients at a small nursing home owned and operated by a religious corporation. The religious tenets of the religious corporation prohibit the intentional taking of human life by oneself or by another. A patient in the nursing home, who has a terminal illness, requests that Dr. Jones assist her in committing suicide. Dr. Jones' religious convictions prohibit both the intentional taking of another human being's life and referral of the patient to a colleague who he knows will assist her in committing suicide.

1) May the patient or her family sue Dr. Jones for refusing to accede to her request for assistance in committing suicide?

2) Must the religious corporation allow physician-assisted suicide for its patients who request it, even though its religious tenets prohibit such conduct?[5]

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[5] Some long-term care facilities have been required by judicial decrees to withdraw feeding and hydration tubes from patients despite the religious or moral objections of the institutions and their employees to withdrawal of life support. *See, e.g., Gary v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (hospital ordered to remove feeding/hydration tube of patient in persistent vegetative condition unless patient could be promptly transferred to another facility); *Matter of Jobes*, 529 A.2d 434, 450-451 (N.J. 1987) (private nursing home prohibited from transferring patient to another institution and ordered to withdraw feeding/hydration tube from incompetent patient despite moral opposition of the institution and its employees). *See also*, Wardle, *supra*, at 211-215.

3) Must the physician or the religious corporation transfer the patient to a facility that will perform physician-assisted suicide?[6]

Scenario 4: Pharmacist Johnson is on duty in the only pharmacy in town. He is filling a prescription for a large amount of barbiturates for a patient he knows to have a terminal illness. Because of the quantity and strength of the prescription, Mr. Johnson is reasonably certain that the drug will be used to terminate the patient's life. His religious convictions will not allow him to participate in a suicide. Mr. Johnson faces several issues as he ponders the situation, including:

1) Is it permissible for him to question the patient about the intended use of the prescription?

2) Is it permissible for him to discuss his concerns with the prescribing physician?

3) May the pharmacy owner require the pharmacist to fill the prescription, or would such an order be a

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[6] Defeated by Washington State voters at referendum in 1991, Initiative Measure 119 would have permitted physician-assisted suicide in Washington State. It explicitly stated that objecting physicians would not be criminally or civilly liable if they refused to assist patients in committing suicide. However, it also explicitly required the objecting physician or health care facility to make a good faith effort to transfer the patient to another physician or facility that would terminate his life. Wash.App. H8-9.

The Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws in 1993, requires a health-care provider to comply with an individual's health-care decision unless the provider declines for reasons of conscience. If the provider or institution declines for reasons of conscience, the patient must be promptly informed and the provider or institution must "immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision." Uniform Health-Care Decisions Act § 7(e)-(g), 9 U.L.A. 220, 239 (1993).

violation of Title VII of the 1964 Civil Rights Act, or applicable state laws, prohibiting discrimination against religious employees?[7]

4) If so, what would constitute a "reasonable accommodation" of the religious employee's refusal to participate in a suicide?

5) If the pharmacy adopts a policy of not filling prescriptions that the pharmacist reasonably believes might be used to commit suicide, will this lack of "service" make it less likely that the pharmacy will be chosen to participate in major health care plans that accept, even promote, physician-assisted suicide as a form of "treatment"?

Scenario 5: St. Mary Hospital is a healthcare and teaching hospital offering medical residency training programs, including programs in geriatrics, oncology, and AIDS treatment. St. Mary adheres to the directives of its sponsoring church, which prohibit the intentional taking of human life, including physician-assisted suicide.

The Accreditation Council for Graduate Medical Education (ACGME) is a nonprofit, private association that evaluates residency programs, based on its own standards. However, the state in which St. Mary Hospital is located bases its accreditation of a hospital entirely upon the recommendation of the ACGME. The ACGME withdraws St. Mary Hospital's accreditation as a teaching hospital, concluding that its programs for training medical residents in geriatrics, oncology, and AIDS treatment are deficient because they do not include actual clinical instruction in physician-assisted suicide.

1) If St. Mary Hospital sues for return of its accreditation, will its claim under the Free Exercise Clause of the

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[7] *See* Wardle, *supra*, at 218 ("[I]n practice, Title VII has provided limited and uneven protection for the rights of conscience of health care workers. Some courts have been grudging in their application of Title VII to health care employees disciplined because of their opposition to abortion.")

First Amendment be outweighed by the ACGME's argument that the government has an overriding interest in providing satisfactory physician education to residents?[8]

2) If St. Mary Hospital loses its accreditation, and thereby loses government funding and reimbursement (since a nonaccredited hospital generally cannot bill for government-funded health care), will it be able to remain open?

3) If medical training programs that refuse to provide actual clinical instruction in the administration of lethal drug dosages to patients are denied accreditation, will medical residents who desire a program in which they are not required to participate in clinical instruction in the administration of lethal dosages to patients be able to find such a program?[9]

If physician-assisted suicide is legalized, it is highly foreseeable that an attempt will be made to condition accreditation for all medical training programs upon the

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[8] The above scenario draws upon an actual case in which a religiously-affiliated hospital lost accreditation for its medical residency training programs in obstetrics-gynecology for a variety of reasons, including its refusal for religious reasons either to provide clinical instruction in abortion or to allow its students to receive such training elsewhere. A federal district court denied the hospital's claim under the free exercise clause to an exemption from the requirements of the ACGME, which the court assumed was a state actor for purposes of licensing medical facilities. The court ruled that the state's interest in "satisfactory physician education" overrode the hospital's religious convictions against providing training in abortion. *St. Agnes Hospital of the City of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990).

[9] *See* Wardle, *supra*, at 193, 221-222 (medical and nursing students are particularly vulnerable to pressure to participate in procedures to which they have moral or religious objections; students with such objections may be discriminated against in the admissions process or penalized during training, if they will not participate in morally controversial procedures.)

inclusion of clinical instruction in physician-assisted suicide. In 1995, the ACGME sought to impose on all medical training institutions a new accreditation standard requiring abortion training in all obstetrics/gynecological residencies. Diane M. Gianelli, *Legislators Seek to Bypass ACGME Abortion Training Rule*, American Medical News, July 17, 1995, at 1. Initially, the ACGME proposed standard required institutions that opposed abortion to make arrangements for residents who did not object to abortion to learn the procedure at another institution. *Id.* at 22. In response, in 1996, Congress prohibited the federal, state, and local governments from discriminating against a health care professional, a hospital, or a residency program because of the person's or entity's refusal to perform, train in the performance of, or make referrals for training in or performance of abortions. 42 U.S.C. § 245(a)(1) (1996). The law specifically provides that residency programs must be accredited if they meet all criteria for accreditation except for a requirement that it train in the performance of induced abortions. 42 U.S.C. § 245(b)(1) (1996).

B. The Courts Below Failed to Adequately Consider the Rights of Conscience of Medical Care Professionals.

The Ninth Circuit casually addressed the deadly dilemma its decision would force upon many physicians when it wrote:

> Recognizing the right to "assisted-suicide" would not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience.

Wash.App. A96.

The court's assertion is completely unsupported in the opinion itself or in reality. The court leaves not only

physicians, but also less-empowered health professionals, at the mercy of supervisors who have the authority to issue orders that they assist in patients' suicides. Physicians will face increased malpractice litigation as physician-assisted suicide becomes the accepted standard of care for all physicians, even those with religious objections. Nor does the decision protect religiously-affiliated health care facilities from state regulations or private lawsuits requiring such treatment.

Ironically, in its decision, the Ninth Circuit relied heavily on language from *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992), suggesting that "the most intimate and personal choices" and "choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." Wash.App. A27. If this standard covers ending one's life by assisted suicide, as the Ninth Circuit holds, then it certainly must cover not having to participate in another's suicide. Assisted suicide, by definition, is not a lone act: It requires one or more assistants. No one should be forced to aid in killing, even if that assistance is necessary for persons desiring to kill themselves – as it most certainly will be for many hospital and nursing-home patients.

An analogous dilemma has already arisen in the context of persons seeking to terminate life-sustaining medical treatment. Some courts have been forced to deal with difficult cases where patients or families request the termination of certain life-sustaining treatments at institutions ethically committed not to deliver such treatments. *See, e.g., Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 639 (Mass. 1986); note 5, *supra*. Other courts have confronted cases arising where nurses or other health-care providers refused on ethical grounds to participate in nontreatment procedures. *See, e.g., Farnam v. Crista Ministries*, 807 P.2d 830 (Wash. App. 1991) (nurse refused to participate in the withdrawal of life-sustaining treatment for an incompetent patient). Such cases will surely multiply when the so-called medical procedure involves actively hastening death rather than allowing death to

occur. Many physicians and medical ethicists see a bright ethical and moral line dividing the two situations, and will refuse to cross that line under any circumstances.[10]

Following the *Farnam* case, Washington state lawmakers added the following provision to Washington's living-will statute:

> No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's . . . refusal to participate in the withholding or withdrawal of life-sustaining treatment.

1992 Wash. Laws, ch. 98, sec. 6. At the very minimum, the court below should have insured similar fundamental protection for the freedom and conscience of all health-care personnel and institutions when it created a right to assisted suicide.[11]

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[10] *See, e.g.*, Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988). *See also*, discussion at pp. 18-21, *infra*.

[11] Drafting, and then passing, comprehensive language that will truly protect health workers' conscience rights will be difficult. As Professor Wardle concluded after surveying the current state and federal "conscience clauses":

> The current patchwork of state and federal conscience clause laws are well-intentioned but obviously and profoundly inadequate. . . . Virtually all are too narrow, cover too few health care providers, in too few situations, are too easily circumvented, and provide inadequate remedies and procedures to be effective. The deficiencies of these statutes have been compounded by the grudging interpretation given such provisions by many courts.

Wardle, *supra*, at 226. Professor Wardle offers a model "Health Care Providers' Rights of Conscience Protection Act." *Id.* at 227.

Protecting the right of health-care institutions, as well as individual practitioners, to refuse to assist patients in committing suicide ensures not only the freedom and conscience of persons working at those institutions, but also shields the freedom and conscience of patients served in them. Opponents of physician-assisted suicide reasonably fear that, if the practice is legalized, then it will lead to cases where patients are put to death without their full and free consent. *See* Yale Kamisar, *Against Assisted Suicide – Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). Indeed, in the Netherlands, the only country where physician-assisted suicide is openly practiced, many cases have been documented in which involuntary euthanasia has occurred despite rules against it and procedures tneoretically designed to prevent its occurrence. *See* Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, 104-13 (1991).[12]

If physician-assisted suicide were legalized in the United States, persons needing hospital or nursing-home care would need to be assured the realistic option to choose an institution where that practice could never happen to them, even when they were weakest and unawares. These important concerns underscore the dangers associated with physician-assisted suicide, and why it is reasonable (indeed compelling) for states to outlaw the practice.

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[12] The 1996 report, *Physician Assisted Suicide and Euthanasia in the Netherlands*, to the Subcommittee on the Constitution of the House Committee on the Judiciary, describes one account of a doctor allegedly "terminat[ing] the life of a nun a few days before she otherwise would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death." *Physician Assisted Suicide* Report, *supra*, at 19. The report concluded that "the doctor had as little respect for the right to self-determination as he had for religious freedom." *Id.*

II. The Second Circuit Wrongly Equated Terminating Life-Sustaining Medical Treatment with Prescribing Lethal Medication in Establishing an Equal Protection Right to Assisted Suicide.

In *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), the Second Circuit correctly identified "rational basis scrutiny" as the appropriate standard of judicial review under the Equal Protection Clause of the Fourteenth Amendment for statutes outlawing assisting suicide. However, on the crucial issue of equating types of terminally ill persons, the panel wrote that "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescription drugs." N.Y.App. 29a-30a. Yet the panel's opinion offered no medical, ethical, or historical authority – indeed, no authority of any type other than its own reasoning from prior decisions – for equating the two groups.

The absence of authority here is telling because it involves a central issue in medical ethics. Although some modern medical ethicists and physicians agree with the panel's conclusion,[13] the great weight of authority maintains that there is a fundamental difference between allowing patients to die by withdrawing or withholding medical treatment and hastening death through medical intervention. This distinction dates at least as far back in Western medical tradition as the ancient Hippocratic Oath. Referring to this oath, this Court once observed, "It represents the apex of the development of strict [ethical] concepts in medicine, and its influence endures to this day." *Roe v. Wade*, 410 U.S. 113, 131 (1973). Under the Hippocratic Oath, which is attributed to the 4th century

[13] *See, e.g.*, Marcia Angell, *Euthanasia*, 319 New Eng. J. Med. 1348, 1350 (1988).

B.C. Greek physician Hippocrates, a physician may refrain from treating patients but may never prescribe any "deadly medicine," even if asked.[14]

A. Physicians and Medical Ethicists Today Distinguish Between Hastening Death and Allowing to Die.

The major Anglo-American professional associations of physicians vigorously maintain this distinction today. Thus, for example, the American Medical Association condemns physician-assisted suicide as "contrary to that for which the medical profession stands" while it condones the withdrawal of life-sustaining treatment if it is in accordance with "the decision of the patient and/or his immediate family."[15] The British Medical Association assumed a similar stance in its 1988 *Euthanasia Report*, which concluded, "There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a nontreatment decision)."[16]

Leading medical ethicists also accept this distinction. For example, the Hastings Center, a prominent national institute for the study of medical ethics, concluded in a

[14] The text of the Hippocratic Oath is widely reprinted, with this quote taken from the Oath as reprinted in Donald D. Millikin, *Oath of Hippocrates*, in 12 Collier's Encyclopedia 137 (1994). For commentary on this distinction, *see* Gaylin et al., *supra*, at 2139.

[15] Quoted from a 1973 resolution of the American Medical Association House of Delegates, reprinted in Thomas D. Sullivan, *Active and Passive Euthanasia: An Impertinent Distinction?*, in *Euthanasia: The Moral Issue* 53, 54 (Robert M. Baird & Stuart E. Rosenbaum, eds. 1989). For reference to a similar position taken by the Judicial Council of the American Medical Association in 1986, see Gaylin et al., *supra*, at 2139.

[16] *Conclusions of a British Medical Association Review of Guidelines on Euthanasia*, in *Euthanasia*, *supra*, at 155.

1987 report that helped shape the right to refuse life-sustaining treatment:

> Some persons who accept this right of patients to decide to forego treatment are concerned nevertheless that the values supporting it, and in particular self-determination, necessarily imply that voluntary euthanasia and assisted suicide are also justified. We disagree. Medical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death of assisting suicide.

Hastings Center, *Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying* 129 (1987). Four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, jointly declared on this point, "Generations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life." Gaylin et al., *supra*, at 2139. In a statement that utterly undermines the Ninth Circuit's position, these four scholars added, "Neither legal tolerance nor the best bedside manner can ever make medical killings medically ethical." *Id.*[17]

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[17] An exhaustive study of the issue by the official New York State Task Force on Life and the Law reached a similar conclusion in 1994. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). Also in 1994, in the litigation spawned by Dr. Jack Kevorkian's practice of physician-assisted suicide, a Michigan appellate court accepted this distinction in the context of considering the constitutionality of a state law against assisted suicide. *Hobbins v. Attorney General*, 518 N.W.2d 487, 493 (Mich. App. 1994). For a fuller discussion of this distinction in the context of the Washington State statute at issue in the present case, see Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 Seattle U. L. Rev. 509, 516-19 (1995).

Given the overwhelming weight of medical and ethical authority against its position, it is understandable that the decision below does not cite any medical or ethical authority for equating physician-assisted suicide with terminating life-sustaining medical treatment. Physicians and medical ethicists typically view the two situations as fundamentally different.

B. The Second Circuit Gave an Inadequate Basis for Equating Physician-Assisted Suicide With the Right to Refuse Treatment.

The *only* evidence that the panel offered to support its equal-protection holding was the citation of New York State statutory and common law regarding the right of terminally ill persons to refuse life-sustaining treatment. It then quoted Justice Scalia's concurring opinion in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 297 (1990) (Scalia, J., concurring), as authority for dismissing "the action-inaction distinction" as irrelevant, leading to its conclusion that there is no legally meaningful distinction between "ordering the discontinuance of . . . artificial life-sustaining processes" and "writing a prescription to hasten death." *Quill*, N.Y.App. 30a. In both cases, the panel wrote, "The ending of life by these means is nothing more nor less than assisted suicide." *Id.* Justice Scalia's comment, of course, did not address the latter act and, as noted above, mainstream medical and ethical opinion simply does not equate the two actions. As the 1987 Hastings Center report concluded, "a reasonable, if not unambiguous, line can be drawn between foregoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide on the other." Hastings Center, *supra*, at 6.

The Second Circuit panel ignored this line and wrongly ordered the state to do likewise. Either the distinction between withdrawing life-sustaining treatment and prescribing lethal medication is sufficient to satisfy rational basis scrutiny, or many of America's most

respected medical ethicists and physicians are irrational regarding an issue of central concern to their profession.

III. The Ninth Circuit Wrongly Characterized the Early Historic Opposition to Suicide Within the Christian Tradition in Establishing a Due Process Right to Assisted Suicide.

In *Quill*, the Second Circuit panel set forth the appropriate tests for determining whether a right to assisted suicide constitutes a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. Of course, a right to assisted suicide has no direct textual support in the language of the Constitution. With respect to such claimed rights, the panel observed:

> Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed. . . . " Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition."

Quill, N.Y. App. 17a (citations omitted).

The Second Circuit panel concluded that neither of these tests were satisfied regarding a right to assisted suicide. "Indeed, the very opposite is true," the panel wrote, adding as follows:

> The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. . . . Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. . . . Clearly, no 'right' to assisted suicide ever has been recognized in any state in the United States.

Id. at 18a-19a (citations omitted). Based on this historical record, the panel declined the invitation to create a substantive due process right to assisted suicide. In doing so, it quoted the Supreme Court's apt warning, "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Id.* at 19a, *quoting Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

The Ninth Circuit did not exercise such reasoned restraint. The majority *en banc* opinion reversed a prior ruling by a three-judge appellate panel that, like the Second Circuit panel, found "that 'a constitutional right to aid in killing oneself' was 'unknown to the past.'" *State of Washington*, Wash.App. A39 (quoting *Compassion in Dying v. State of Washington*, 49 F.3d 586, 591 (9th Cir. 1995)). Responding expressly to this finding, and implicitly to the Second Circuit panel, the *en banc* opinion stated that "our inquiry is not so narrow. Nor is our conclusion so facile. The relevant historical record is far more checkered than the [panel] majority would have us believe." *Id.* In an apparent effort to provide a traditional foundation for a right to assisted suicide, the Ninth Circuit then presented its own view of the relevant history, including the suggestion that early Christians accepted suicide. We leave it to other *amici* to critique the entire history, but wish to correct the record regarding the historic Christian view of suicide.

A. Contrary to the Suggestion of the Ninth Circuit, Early Christians Firmly Repudiated Suicide.

There was no moral acceptance of suicide within the early Christian church. Beth Spring & Ed Larson, *Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care* 105-19 (1988). No recognized historian has documented instances of early Christian church leaders condoning suicide, as that term is commonly understood, the voluntary taking of one's own life. Quite to the contrary,

they uniformly condemned self murder. *See, e.g.*, Robert Barry, *The Development of the Roman Catholic Teachings on Suicide*, 6 Notre Dame J.L., Ethics & Pub. Pol'y 466-468 (1995); Darrel W. Amundsen, *The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide, in Physician-Assisted Suicide: Ethics, Medical Practice, and Public Policy* (R.F. Weir, ed., 1997).

Even the Ninth Circuit opinion recognized that the influential bishop and Christian scholar Augustine (354-430 A.D.) denounced suicide as a "detestable and damnable wickedness" and that thereafter "the Christian view that suicide was in all cases a sin and crime held sway for 1,000 years." *State of Washington*, Wash.App. A43-44. But the court majority suggested that Augustine's opposition turned the Christian Church against a previously tolerated practice. *Id.* Yet the historical record shows consistent Church opposition to suicide from the earliest days. Regarding the pre-Augustinian period, one scholar recently observed:

> The early orthodox Christian church issued few official moral condemnations of suicide, or of any action for that matter, even though the great proportion of early Christian writers condemned deliberate self-killing vigorously. The lack of "official" condemnations of suicide, however, does not mean that the early Church endorsed or permitted it. The early Church produced many theological and moral writings against suicide, and these views later came to be expressed in councillor and juridical documents after Constantine granted legal status to the Church.

Barry, *supra*, at 467 (footnote omitted).

The notable pre-Augustinian moral and theological writings by recognized Church leaders condemning the practice of suicide include ones by Clement of Alexander (ca.155-ca.220 A.D), Tertullian (ca. 160-ca.220 A.D.), Basil of Caesarea (ca.330-379 A.D.), and Jerome (ca.342-419 A.D.), as well as the anonymous "Epistle to Diognetus"

and Clementine "Homilies." *Id.* at 467 n. 101. The great Church leader Justin Martyr (ca.100-165 A.D.) wrote that suicide "will be opposing the will of God."[18] In his *Divine Institutes*, the theologian Lactantius (ca.240-320 A.D.) commented on suicide that "nothing can be more wicked than this."[19] Bishop John Chrysostom (349-407 A.D.) affirmed that "if it is base to destroy others, much more is it to destroy one's self."[20] Milan's noble-born scholar-bishop, Ambrose (ca. 339-397 A.D.), advised "that holy Scripture forbids a Christian to lay hands on himself."[21]

Further evidence for early Christian opposition to suicide is demonstrated by the rapidity with which the practice passed from public tolerance as Christianity spread throughout the Roman world. One of the leading authorities cited by the Ninth Circuit, Thomas Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1 (1985), notes:

> The gradual dominance of Christianity in the Roman Empire, culminating in the conversion of the Emperor Constantine in the 4th century A.D., worked a transformation in the cultural attitude toward suicide. Imbuing all strata of the Roman world with its spiritual principles, Christianity provided a view of life that was itself inimical to suicide.

Id. at 26. Once common suicide practices, such as disgraced generals falling on their swords, virtually vanished. Barry, *supra*, at 466. The infanticide of unhealthy or

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[18] Justin Martyr, 2 *Apology* 4, in 6 *Fathers of the Church* 123 (1948).

[19] Lactantius, *Divine Institutes* 3.18, in 7 *Ante-Nicene Fathers* 89 (1951).

[20] John Chrysostom, *Commentary on Galatians* 1:4, in 13 *Select Library of Nicene and Post-Nicene Fathers of the Christian Church* 5 (1977).

[21] Ambrose, *Concerning Virgins* 3.7.32, in 10 *Select Library, supra*, 2d ser., 386 (1979).

unwanted children was absolutely proscribed for the first time. Rodney Stark, *Rise Of Christianity* 124 (1996). In deeds as well as words, early Christians rejected suicide and euthanasia.

In contrast to the consistent historical record of early Church opposition to suicide, the Ninth Circuit writes, "The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven." Wash.App. A42. Yet the authority cited by the court for this view went on to state that, even though the Bible "contains no explicit prohibition against suicide," nevertheless, "the early Christians incorporated Judaic attitudes and Platonist philosophy which both opposed the practice." Marzen, *supra*, at 26. In particular, the Ninth Circuit cites the early Christian martyrs, who died rather than renounce their faith, as examples of the acceptance of suicide among early Christians, and quotes from a 200-year-old history of the Roman Empire to describe the nature and extent of the practice. Wash.App. A42-43. Yet submitting to forced martyrdom is not equivalent to modern practices of voluntary suicide, and modern scholarship suggests that earlier historians grossly exaggerated both the number of early Christian martyrs and the eagerness with which they met their fate. *See, e.g.*, Stark, *supra*, at 179-184. Indeed, as noted above, one of the most famous early Christian martyrs, Justin, preached and taught against suicide.

The Ninth Circuit also turns to the Bible to support its position. Here too, however, its reliance is misplaced. The court wrote:

> The stories of four suicides are noted in the Old Testament – Samson, Saul, Abimlech [sic], and Achitophel [sic] – and none is treated as an act worthy of censure. In the New Testament, the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance.

Wash.App. A42 n. 25. Actually, there are other examples of suicide recorded in the Bible, but many more examples of faithful Jews and Christians resisting the temptation to

commit suicide. *See* Barry, *supra*, at 454-58. Of the five Biblical suicides identified by the Ninth Circuit, all but Samson were persons utterly alienated from God, and Samson died as a captured warrior in an act intended to kill Israel's enemies. *Id.*, at 452-457. Saul attempted to kill himself by falling on his sword, after losing God's favor and losing in battle. However, his fall on his sword left him "in the throes of death," and he begged an Amalekite soldier to kill him. 2 *Samuel* 1:9. The Amalekite "stood over him and killed him, because I knew that after he had fallen he could not survive." 2 *Samuel* 1:10. King David had the Amalekite killed for his killing of Saul. 2 *Samuel* 1:15-16. This would seem to suggest that assisted-suicide was not met with approval, at least by King David. Like Saul, Abimelech also disobeyed God as a leader of Israel: He murdered his 70 brothers and later asked to be killed after suffering a mortal wound. *Judges* 9:54. Ahithophel was a disloyal counselor to David who strangled himself after his treason was discovered. 2 *Samuel* 17:21-23. Judas hanged himself after betraying Christ, which Marzen notes with mock understatement "hardly recommended suicide to the early Christian church." Marzen, *supra*, at 26. These are not models for Christian behavior, and their suicides underscored their depravity. *See, e.g.*, Barry, *supra*, at 456-57. There simply is no Biblical acceptance of suicide.

In claiming an ancient acceptance of suicide, the Ninth Circuit relied on the writings about suicide of Alfred Alvarez and Emile Durkheim. Wash.App. A42. Neither was an historian, however. Alvarez, who wrote in defense of suicide, is a poet who writes of himself that he "began as a literary critic, but by the end of the 1960s had grown weary of writing books about other people's books, so effectively gave up criticism in order to concentrate on his own creative work." Alfred Alvarez, in 33 *Contemporary Authors*, n. ser. 6 (1991). One might suspect his history as being a creative effort. *See, e.g.*, Darrel W. Amundsen, *Did Early Christians "Lust After Death"?* 12 Christian Research J. (Spring, 1996). Durkheim was a

preeminent nineteenth century French sociologist who devised and utilized a broad definition of suicide that included, in his own words, "All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." Emile Durkheim, *Suicide: A Study in Sociology* 44 (J.A. Spaulding and G. Simpson, trans., 1951). Thus, for Durkheim, suicides included soldiers and martyrs who knowingly gave their lives for political or religious causes – a subjective desire to die was irrelevant. *See id.* at 227. The writings of Alvarez and Durkheim do not provide historical support for early Christian acceptance of the type of suicide at issue in this case.

The Ninth Circuit's attempt at Biblical interpretation illustrates the danger of judicial interpretations of religious doctrine. It is hard to "imagine a subject less amenable to the competence of the federal judiciary, or more deliberately to be avoided where possible." *Lee v. Weisman*, 112 S. Ct. 2649, 2671 (1992) (Souter, J., concurring).

B. The History and Tradition of the Nation and the State of Washington Firmly Oppose Any Right to Assisted Suicide.

The test that the Ninth Circuit apparently is trying to satisfy with its analysis of historical attitudes toward suicide describes fundamental liberties as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). *See Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). By its terms, this test looks only to American history and tradition – which is what the Second Circuit panel did in finding no right to assisted suicide under the Due Process Clause. *Quill*, N.Y.App. 18a-19a. The same result should follow for the Washington State law against assisting suicide at issue in the Ninth Circuit case. If the history and tradition of this statute are any guide, they strongly support upholding it as constitutional.

Restrictions against assisting suicide were in place in Washington even before the region became a state. The second bill passed by the first territorial legislature for Washington, in 1854, provided, "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter." 1854 Wash. Laws p. 78, § 17. That law or one similar to it has remained on the books in Washington ever since. *See* 1869 Wash. Laws p. 201, § 17; 1873 Wash. Laws, p. 184, § 19; and 1909 Wash. Laws, ch. 249, § 135.

In its present form, the Washington law also reflects the relatively recent influence of the Model Penal Code, which was crafted by the leading criminal law scholars of the mid-twentieth century. Stanford Kadish, *The Model Penal Code's Historical Antecedents*, 19 Rutgers L.J. 521 (1988). The drafters of the Model Penal Code considered the arguments in favor of decriminalizing assisting suicide, but ultimately decided to retain that traditional feature of Anglo-American criminal law. In the commentary to the Code, the drafters noted that "the interests in the sanctity of life that are represented by the criminal homicide law are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." American Law Institute, *Model Penal Code and Commentaries*, I, 100 (1985). Indeed, it is difficult to think of a more effective way of discouraging suicide than to stop others from helping the victim.

In the past thirty years, following the publication of the Model Penal Code, eight states passed new statutes specifically outlawing assisted suicide and eleven other states, including Washington in 1975, revised their existing statutes. Marzen, *supra*, at 100. In 1991, Washington State voters rejected an initiative measure that would have legalized physician-assisted suicide.[22] A year later,

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[22] *See* N.Y. Times, Nov. 7, 1991, sec. B, at 16.

the Washington State legislature added a provision expressly excluding physician-assisted suicide from the state's advance-directives statute. 1992 Wash. Laws, ch. 98, sec. 10. In short, the history of the Washington State law against assisting suicide demonstrates an acceptance of such statutory bars that is deeply rooted in both the Nation's and the State's history and tradition.[23]

CONCLUSION

For the above reasons, the decisions below should be reversed.

Respectfully submitted,

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[23] For a fuller analysis of the history of the Washington State law against assisting suicide, see Edward J. Larson, *Prescription for Death: A Second Opinion*, 44 DePaul L. Rev. 461, 462-66 (1995).

APPENDIX

INTERESTS OF THE *AMICI*

The **Christian Legal Society** ("CLS"), founded in 1961, is a nonprofit ecumenical professional association of 4,000 Christian attorneys, judges, law professors, and law students with chapters in every state and at 85 law schools. CLS' legal advocacy and information arm, the Center for Law and Religious Freedom, defends religious exercise and the sanctity of human life in state and federal courts at all levels.

The Society is committed to religious liberty because the founding instrument of this nation acknowledges as a "self-evident truth" that all persons are divinely endowed with rights that no government may abridge nor any citizen waive. Declaration Of Independence (1776). Among such inalienable rights are those enumerated in (but not conferred by) the First Amendment, the first and foremost of which being religious liberty. The right sought to be upheld here inheres in all persons by virtue of its endowment by the Creator, Who is acknowledged in the Declaration. It is also a "constitutional right," but only in the sense that it is recognized in and protected by the U.S. Constitution. Because the source of religious liberty, according to our nation's charter, is the Creator, not a constitutional amendment, statute or executive order, it is not merely one of many policy interests to be weighed against others by any of the several branches of state or federal government. Rather, it is foundational to the framers' notion of human freedom. The State has no higher duty than to protect inviolate its full and free exercise. Hence, the unequivocal and non-

negotiable prohibition attached to this, our First Freedom is "Congress shall make **no** law. . . . "

The **Christian Medical and Dental Society** ("CMDS") was founded in 1931 and today represents over 10,500 members – primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Among other functions, the CMDS Medical Ethics Commission gathers together member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Society.

CMDS has through this democratic process arrived at a life-honoring consensus among the membership on the issue of physician-assisted suicide. CMDS views this life-honoring principle as essential to protecting the lives and best interests of our patients, practicing medicine conscientiously according to long-standing Hippocratic and religious principles, and preserving the public respect accorded to physicians as guardians of health and life.

The **Nurses Christian Fellowship** was founded in 1948 and is a department of InterVarsity Christian Fellowship. It represents approximately 2000 nurses and publishes *The Journal of Christian Nursing*, which has over 9000 subscribers. The Nurses Christian Fellowship represents nurses who are students and faculty in schools of nursing, and nurses who work in hospitals, long-term care facilities, and health agencies in the community.

The **Christian Pharmacists Fellowship International** (CPFI) was incorporated as a non-profit group of Christian pharmacists in 1984 with the express purpose of promoting the integration of Biblical principles into the global practice of pharmacy. CPFI has 1000 professional members, consisting of those practicing all branches and specialties within the field of pharmacy. The position taken in this brief is consistent with a position paper filed by CPFI, published in the October, 1996 issue of *The Annals Of Pharmacotherapy*.

The **Fellowship of Christian Physician Assistants,** founded in 1980, has 700 member physician assistants. Working with physician supervision in hospitals, long-term care facilities, and clinical settings, physician assistants provide physician services, including highly technical services, in all medical specialties. The members of the Fellowship of Christian Physician Assistants are certain that physician assistants will be routinely delegated the task of carrying out the orders for physician-assisted suicide.

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In The

Supreme Court of the United States

October Term, 1996

VACCO *et al.*, *Petitioners*, v. QUILL *et al.*, *Respondents.*

WASHINGTON *et al.*, *Petitioners*, v. GLUCKSBERG *et al.*, *Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Second And Ninth Circuits

BRIEF AMICI CURIAE OF THE NATIONAL LEGAL CENTER FOR THE MEDICALLY DEPENDENT & DISABLED, INC., on behalf of its client population; JULIE L. AARDAPPEL, by and through her guardian Gary W. Aardappel; LORRAINE BANKS; JOHN THOMAS "JACK" DOUCETTE, by and through his guardian Margaret Doucette; KATHLEEN LUMBRA; BRUCE W. MATSON and KEITH C. MATSON, by and through their guardians Paul C. and Rosemarie Matson; SALLY BEACH, R.N., individually and on behalf of her terminally ill patients; DR. DAVID L. VASTOLA, D.O., individually and on behalf of his terminally ill patients; DISABILITIES PERSPECTIVES; THE ETHICS AND ADVOCACY TASK FORCE OF THE NURSING HOME ACTION GROUP; AND THE MICHIGAN HANDICAPPER CAUCUS; IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Your amici adopt the Questions Presented by the Petitioners State of New York and State of Washington.

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INTERESTS OF THE AMICI CURIAE

Your amici include persons with terminal conditions or other severe disabilities, and health care professionals or organizations that serve or represent such persons. Your amici have represented or have been amici or proposed intervenors in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996); *Hobbins v. Attorney Gen. of Mich. (People v. Kevorkian)*, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 131 L. Ed. 2d 723 (1995); *Lee v. Oregon*, Nos. 95-35804, -35805, -35854, -35948, -35949 (9th Cir. filed August 7, 1995) (decision pending); or *McIver v. Krischer*, No. CL-96-1504-AF (Fla. Cir. Ct. Palm Beach County filed Feb. 16, 1996) (challenging Florida's criminal ban against assisted suicide on state and federal constitutional grounds).

The National Legal Center for the Medically Dependent and Disabled, Inc., is a not-for-profit, public interest law firm chartered to represent and defend the rights and interests of persons who are critically or terminally ill, severely disabled, or otherwise medically dependent. The outcome of these cases will directly affect the rights and interests of the National Legal Center's client population.

Disability Perspectives is a California-based, national organization of persons with disabilities. Many of its members have disabilities that would result in death without medical treatment, and a majority of these members are indigent. Disabilities Perspectives works to protect persons with disabilities from abuse by caregivers and to improve the quality of life for persons with disabilities.

The Michigan Handicapper Caucus is a disability rights organization that advocates on behalf of its members and other persons with disabilities. The majority of the Caucus' members have disabilities, many of which are terminal, and are indigent.

The Ethics and Advocacy Task Force is a committee of the Nursing Home Action Group, a non-profit Minnesota-

based corporation with membership throughout the United States. The majority of its membership have disabilities, many of which are terminal, and are indigent. The Group advocates for disability rights, with a particular focus on persons with disabilities who are under guardianship and those residing in long-term care facilities.

Several individual amici have terminal conditions: Lorraine Banks (malignant breast cancer), John Thomas "Jack" Doucette (insulin-dependent diabetes), and Kathleen Lumbra (primary biliary cirrhosis of the liver). Several of your individual amici have severe disabilities and are under guardianship: Julie L. Aardappel, John Thomas "Jack" Doucette, Bruce W. Matson, and Keith C. Matson. These individuals or their guardians know that if assisted suicide for persons with terminal conditions is constitutionalized, then they and other similarly situated persons would be exposed to having assisted suicide requested or ordered for those of them who are or become incompetent. In addition, those not under guardianship — all of whom have a history of depression — know that in a future depressive episode, they will be in danger of being provided assisted suicide rather than suicide prevention services.

Dr. David L. Vastola, D.O., and Sally Beach, R.N. provide health care services to persons with terminal conditions and other severe disabilities. They know that the lives of many of their patients would be threatened were assisted suicide recognized as a right; although they are conscientiously opposed to assisted suicide, they would be required to participate in the practice if it were held to be a constitutionally protected.

This brief was written with the support of funds provided by the Alliance Defense Fund.

Your amici have obtained consent to file this brief from counsel for all of the parties to this action. Copies of letters of consent are being filed concurrently with this brief.

SUMMARY OF THE ARGUMENT

This brief will explore the jurisprudential and practical legal consequences that necessarily arise from recognition of a constitutionally protected right to assisted suicide. It will demonstrate that persons with terminal conditions would lose rather than gain through establishment of any such right.

The purportedly narrow scope of the right claimed by the lower courts reveals that their holdings are rooted in the proposition that the State can have no legitimate interest in protecting the lives of persons deemed to have a diminished quality of life, such as persons with terminal conditions. Such a jurisprudence necessarily diminishes the constitutional status of these persons and their rights in order to justify their unequal treatment under the law.

Although this Court has held that the State may maintain an unqualified interest in the protection of human life, the lower courts deem this interest, and its corollary interest in the prevention of suicide, illegitimate as applied to persons with terminal conditions. In order to justify this conclusion, the courts below impute to the Fourteenth Amendment a sliding-scale rule by which the state's interest in the protection of human life and in the prevention of suicide diminishes as a person's perceived quality of life declines. Incorporation of such a sliding-scale rule into constitutional jurisprudence reverses the decisions of New York's highest court, transforms the Fourteenth Amendment from a shield that protects human life into a sword that threatens it, and imputes to the Constitution itself the view that certain persons are not worthy of the full protection of law and may be treated unequally.

The boundaries of any category (such as "terminal condition") that defines a constitutionally devalued class of persons in relation to their perceived quality of life are inherently vague and expansive. As a consequence of incorporating a sliding-scale rule into the Fourteenth Amendment, the State would be required to treat devalued persons unequally under

its laws preventing self-murder and would also be permitted to discriminate in many other ways — as in other criminal laws intended to protect life and in social and economic programs necessary to sustain life. In addition, public entities would be compelled to subsidize assisted suicide services if the State chooses to support hospice and other similar services.

Although the lower courts purport to recognize a right to assisted suicide only for competent adults who are terminally ill, any such limitations are illusory. The lower courts explicitly contemplate extension of the right to assisted suicide to incompetent, non-terminal persons. Furthermore, both the refusal of treatment and abortion precedents on which they rely would necessarily require such an extension of the right to incompetent, non-terminal persons. Thus, acceptance of a right to assisted suicide would necessarily sanction nonvoluntary killing of incompetent persons since the right would, by operation of existing law, be imputed to third parties to exercise on behalf of such persons.

For persons with terminal conditions, recognition of a right to assisted suicide would abolish the presumption embodied in suicide prevention laws that suicidal ideation is the product of mental or emotional illness. Abolishing this presumption for the terminally ill is unwarranted by psychological fact and by court precedents. Moreover, abolishing the presumption as to persons with terminal conditions would necessarily permit suicides that are the product of mental or emotional illness rather than competent choice.

Persons with terminal conditions qualify as persons with disabilities under the Americans with Disabilities Act (ADA). Thus, recognition of a right to assisted suicide for such disabled persons would sanction discrimination against them contrary to the policy and plain language of the ADA. Assisted suicide cannot be regarded as a special accommodation or benefit for those with terminal disabilities under the ADA any more than a race-based exception to assisted suicide law would be permissible under constitutional law.

Alternatively, if assisted suicide is recognized as a right for persons with terminal disabilities, then the ADA would require that homicide be allowed for such persons who are unable to kill themselves.

ARGUMENT

I. INTRODUCTION

This brief explores the jurisprudential and legal consequences that necessarily flow from invention of a constitutionally protected right to assisted suicide for persons with terminal conditions or other severe disabilities, such as your amici and those they represent and serve. The courts below assume that assisted suicide would so benefit the terminally ill that any abuse or harm that results would be tolerable — or remedied by legislative initiatives taken under benevolent judicial guidance and oversight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 832-834 (9th Cir. 1996) ("*Compassion*"); *Quill v. Vacco*, 80 F.3d 716, 731 (2nd. Cir. 1996) ("*Quill*"). As your amici will show, however, recognition of an assisted suicide right that overrides otherwise uniformly applicable bans would so devalue the constitutional status of persons with terminal conditions that abuse and harm is certain to occur and meaningful regulation would be impossible.

II. DIMINISHED CONSTITUTIONAL STATUS FOR PERSONS WITH TERMINAL CONDITIONS RESULTS FROM A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES DISCRIMINATORY EXCLUSION OF SUCH PERSONS FROM THE PROTECTION OF OTHERWISE UNIFORM LAWS BANNING ASSISTED SUICIDE.

At the heart of the claim for recognition of a right to assisted suicide lies the question: Does the State have any constitutional basis to deter those who provide others with

the means to kill themselves? In the cases now before this Court, however, the inquiry is reframed as a special pleading: Does the State have any constitutional basis to deter those who provide others with the means to kill themselves *when they are dying anyway*? Thus presented, the inquiry pits the power of the State against the hopelessly ill who merely want help to quickly and efficiently seal their own fates.

Your amici ask instead: On what basis may the Constitution be construed to *exclude* persons with diminished life expectancies from the equal protection of laws that forbid assisted self-murder? Does the Fourteenth Amendment intend that the constitutional status and the right to live of persons hinge on quality-of-life or actuarial status?

Both lower courts recognized that the state's interest in the protection of human life, and the corollary interest in the prevention of suicide, will override a purported fundamental liberty or right to assisted suicide in most cases. Indeed, this invented "liberty" or "right" may hardly be exercised at all — *except* by those among the supposedly small segment of the population that is terminally ill, and then only with the help of a physician.[1] The exercise of no other substantial right or liberty is so narrowly circumscribed. If the abortion liberty were like the assisted suicide right as the lower courts conceive of it, then only women whose lives were threatened by continued pregnancy or some other similarly serious condition could obtain an abortion.

In fact, the reasoning of the lower courts is rooted in the proposition that the State can have no constitutional interest in protecting the lives of certain persons — and does not stem from any firm confidence in the existance of any substantial liberty interest in assisted self-killing. The constitutional value of those with "terminal conditions" is necessarily

[1]A "physician only" rule for assisted suicide absurdly assumes that the Constitution recognizes that the State has an enforceable interest in guaranteeing sure death for certain persons, but no enforceable interest in protecting their lives.

discounted as if they are deemed non-viable: In effect, they are demoted to fetal status and denied full personhood.

The New York and Washington statutes uniformly banning assisted suicide presumably protect against some harm or suggest that some benefit would be lost in their absence. To exclude persons with terminal conditions from the protections they provide assumes, as a matter of constitutional law, that these persons cannot benefit from these laws as others or that whatever harm that might befall them without the protection of these laws is of little or no consequence. Such an assumption lacks any basis in the text of the Fourteenth Amendment and cannot be reconciled with the decisions of this Court.

A. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons to the State Would Be Contrary to Its Purpose and the Precedents of This Court.*

The "State may properly decline to make judgments about the 'quality' of life...and may simply assert an unqualified interest in the preservation of human life." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 282 (1990). In virtual defiance of this conclusion, however, the lower courts held that the Constitution not merely permits, but *compels* the State to qualify its interest in life so that at least the terminally ill may secure the help of others to kill themselves. Construed in this manner, the Fourteenth Amendment, whether by way of its Due Process or Equal Protection Clause, mandates State *dis*interest in their fates. Constitutional interpretation is thus used to accomplish what this Court refused to permit by way of statutory construction: carving out an exception for the terminally ill in an otherwise uniformly applicable statute. *Cf. United States v. Rutherford*, 442 U.S. 544 (1979) (no exception implied in the federal Food, Drug, and Cosmetics Act for terminally ill cancer patients to secure Laetrile).

Thus, the *Compassion* court held that the "strength" of the state's interest in protection of life is necessarily "dependent on relevant circumstances", including the "medical condition" of the person. *Compassion*, 79 F.3d at 817. According to the court, the state's interest in life must vary since, otherwise, "capital punishment[,]...the draft, as well as the defense budget would be unconstitutional." *Compassion*, 79 F.3d at 817 n. 72. By this the court absurdly suggests that the State must stand aside as terminally ill citizens are exposed to purveyors of lethal drugs as the price to be paid for executing convicted murderers and engaging in foreign war.

Moreover, the *Compassion* court recognizes the force of the state's interest in prevention of suicide, but only when "the senseless loss of life taken prematurely" is involved or when the victim could be "restored to a state of physical and mental well-being." *Compassion*, 79 F.3d at 821, 822. The state's interest in preventing suicide for those "in a debilitated state" is, however, "of comparatively little weight." *Id.* According to the court, the Constitution therefore forbids the State from intervening to protect debilitated people while permitting it to protect others.

In *Quill*, the court denies that the State "can possibly have [an interest] in requiring the prolongation of a life that is all but ended," and continues, "Surely, the state's interest lessens as the potential for life diminishes." *Quill*, 80 F.3d at 729, citing *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) ("We think that the state interest [in preserving life] weakens and the individual's right to privacy grows as...the prognosis dims.") By imputing to the Constitution a *Quinlan*-type, sliding-scale standard for evaluating the value of persons, the *Quill* court thus imposes on New York a rule that has been specifically rejected by the state's highest court, as this Court held in *Cruzan* that it might do.

The New York Court of Appeals explained that its precedents on declining treatment "considered the patients' physical condition relevant *only* because...[the court was] required

to determine whether those were the circumstances in which the patients intended to decline the medical care. The requirement was imposed by the patient, not the State." *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 229, 551 N.E.2d 77, 82 (1990) (emphasis added). Under New York's rule, patients' life-sustaining treatment may be declined "not because the State consider[s] their lives worthless, but because the State value[s] the right of the individual to decide what type of treatment he or she should receive under particular circumstances." *Id.* In this regard, the *Fosmire* court merely underscored its earlier holding that "no person or court should substitute its judgment as to what would be an acceptable quality of life of another." *In re Westchester County Medical Ctr. (O'Connor)*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613 (1988).

The New York rule mirrors Missouri's, which this Court upheld in *Cruzan*, 497 U.S. at 282. The Missouri Supreme Court had rejected a sliding-scale standard, basing its decision instead "on the principle that life is precious and worthy of preservation without regard to its quality." *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc). The Missouri court observed, "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified." *Id.* at 420. The court regarded the claim that a patient will not "recover" from a medical condition as "but a thinly veiled statement that her life in its present form is not worth living. Yet a diminished quality of life does not support a decision to cause death." *Id.* at 422. It specifically repudiated the "reasoning upon which *Quinlan* and cases following it rely.... We have found them wanting and refuse to eat 'on the insane root which takes the reason prisoner'." *Id.* at 413 n.5, *quoting* Shakespeare, *MacBeth*, act 1, sc. 3.

Plainly, therefore, the rationales of both the *Compassion* and the *Quill* courts conflict with this Court's decision in *Cruzan*, where it held that States may decline to adopt a sliding-scale rule. Not only this, but both lower courts in effect

hold that the Fourteenth Amendment *incorporates* such a rule — and, as a consequence, mandates that States must devalue their interest in protection of human life in accord with some sort of "quality of life" assessment. The command of the Constitution that the "State cannot so deem a class of persons a stranger to its laws" (*Romer v. Evans*, __ U.S. __, 116 S.Ct. 1620, 1629 (1996)) becomes a command that it must.

The common law regarded suicide and assisted suicide as offenses "against the king, who hath an interest in preservation of all his subjects." 4 W. Blackstone, *Commentaries* *189. To the contrary, say the lower courts: The Constitution informs the State that it has such an interest in only those citizens who pass some quality-control test.

Such an incredible construction of the Fourteenth Amendment transforms it from a shield that recognizes the substantive worth of the life of each person into a sword that actually threatens the lives of those who fail to pass the test. The Framers of the Amendment, who wrote that "life" may not be deprived without due process, could not have intended such a result. Nor could the Framers have intended that the Amendment in fact requires the State to treat persons *un*-equally by excluding them from full protection of their homicide codes. To impute such a purpose to the Amendment mocks its very origins — intended to assure full legal personhood of the former slaves who were once deemed to lack a requisite "quality" of life.

Adoption of a sliding-scale standard as a constitutional rule would in fact attribute to the Constitution itself the forbidden view that some persons "are not as worthy or deserving as others." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1984). It would weave into the very fabric of the Constitution a policy that mandates "permitting the destruction of unworthy life." *See* Karl Binding & Alfred Hoche, *Permitting the Destruction of Unworthy Life* (1920), *reprinted in* 8 Issues in L. & Med. 231 (1992). At the very least, it would return this Court to the discredited jurisprudence of *Buck v. Bell*, 274 U.S. 200 (1927).[2]

The right to live is "the right to have rights." *Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring). As such, "neither liberty nor justice would exist if it were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). Yet for some, the lower courts would qualify this right and prevent the State from protecting it for them as it does for others. If the lower courts' reasoning were accepted by this Court, then it might rightly be said of the Constitution itself: "It identifies persons by a single trait" — some quality of life, such as a terminal condition — "then denies them protection across the board", thereby "singling out a certain class of citizens for disfavored legal status or general hardships." *Romer v. Evans*, 116 S. Ct. at 1628.

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[2] In finding a constitutional right to assisted suicide based on the sliding-scale rubric, a Michigan trial court opined:

> Although some cases have suggested that the state interest in preserving life should be blind to the quality of life, a number of cases suggest that the state's interest in preserving life does have a qualitative component.... More to the point is *Buck v. Bell*[, 274 U.S. 200 (1927)]. In that case, the United States Supreme Court upheld a state statue that required the sterilization of certain women. The Court found that the state in that case has a sufficient interest to avoid the creation of certain life because the state concluded the quality of such life was too low and too much of a burden on society to permit. As a result of this decision of the United States Supreme Court, one could fairly ask, if the state is allowed to prevent the creation of life because it deems the resulting quality too low, how can it deprive a person of the right, under certain circumstances, to come to that same conclusion with respect to their own life?

People v. Kevorkian, No. 93-11482, slip op. at 27-28 (Mich. Cir. Ct. Wayne County Dec. 13, 1993) (Kaufman, J.), *quoted in* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 808 (1994).

B. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons Would Sanction Abuse and State Discrimination.*

In the jurisprudential scheme designed by the *Quill* and *Compassion* courts, the Fourteenth Amendment blinds the State to any harm that might befall those with "terminal conditions" at the hands of suicide assisters. The terminally ill become constitutional semi-persons: free to secure the means to kill themselves with the help of others if they choose, but isolated whether or not they so choose from the protection that the State provides to everyone else. Acceptance of the scheme's core premise — that the Constitution requires the state's interest in the protection of human life to balloon and deflate in tandem with some measure of life's "quality" — would have revolutionary jurisprudential implications and catastrophic personal consequences for many of the most vulnerable among us.

First, the inherent difficulty in defining the nature or scope of any constitutionally cognizable category based on a certain "quality" of life portends confusion, abuse, or both. In the context of the present case, for example, physicians cannot often say with any reasonable medical certainty either that a condition is "terminal" or that a patient will die within a fixed time frame. Joanne Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311 (1996) (Special Issue). Those with "terminal" conditions may include anyone who will die *without* treatment or care, anyone who will die shortly no matter what is done for them, and the entire range of patients in between. *See* Yale Kamisar, *The "Right to Die": On Drawing (And Erasing) Lines*, 35 Duquesne L. Rev. 481 (1996) (Special Issue); Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 814-9. If proximity to death is the variable that governs when the interest in protecting life diminishes, then advanced age alone should warrant assisted suicide: When a person's shelf-life has expired, then she or he should be

deemed beyond the constitutional pale. The *Compassion* court implies that "terminal condition" may be defined as any court, legislature, or physician chooses with constitutional impunity. 79 F.3d at 831. Acceptance of the court's suggestion, however, would entail potential devaluation of the lives of persons on the basis of virtually any quality that diminishes one's life-span.

By employing equal protection analysis, the *Quill* court directly linked the definition of "terminal condition" that might be used for the purpose of assisting suicide to definitions used in the law that governs refusal of life-sustaining treatment. The "right" to assisted suicide thus waxes or wanes as state law permits or forbids such treatment to be declined in a particular circumstance. Apart from its statutory law that governs declining treatment in specific ways and circumstances, however, New York generally permits any adult to refuse any form of treatment in any circumstance. *See In re Storar*, 52 N.Y.S.2d 363, 420 N.E.2d 64, 71 (N.Y. 1981), and the cases there cited. Fully consistent application of the *Quill* analysis would thus sanction assisted suicide for any person — unless the common law rule on declining treatment is severely modified. So it turns out that any supposed definitional limitation on the exercise of a "right" to assisted suicide based on New York treatment refusal law is as chimerical as the concept of "terminal condition" standing alone.

Second, even assuming that the nature and scope of some "quality" of life can be defined in a constitutionally cognizable way, other circumstances and conditions may have an equal or greater claim to state "disinterest". Chronic, painful, and seriously but not life-threatening conditions may impose burdens on the individual, the caregiver, or the State significantly greater than any which accompany terminal conditions. On what possible basis may the Constitution require the State to adopt a posture of disinterest toward the assisted suicides of the terminally ill, yet deny those with painful or disabling conditions the same access to purveyors of lethal means?

Moreover, if the State *must* remain disinterested when those who are sick or disabled seek suicide assistance, then it *might* decline to consistently assert its interest in the protection of life for whole other classes and categories of persons. If the lives of dying or disabled people lack sufficient interest to the State as a matter of constitutional law, then the State might reasonably conclude on similar grounds that, for example, the indigent and unemployable should likewise be specially eligible for assisted suicide.

More generally, if the state's interest in the protection of life diminishes as death approaches, then the State would be justified at least in imposing a lesser penalty for murder of terminally ill persons than it does for the murder of others. Likewise, the State would be justified in specifically refusing to fund medical and other necessary services for those with terminal conditions.

On the other hand, the State would be compelled to subsidize assisted suicide services if it chooses to continue to subsidize hospice or other forms of end-of-life health care. This Court has held that a legitimate governmental interest in fetal life was sufficient to justify funding childbirth services, while refusing to fund abortion. *Harris v. McRae*, 481 U.S. 297 (1980). *See also Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977). But the rationale for a right to assisted suicide reflected in both lower court decisions presumes that there can be no legitimate basis to distinguish between decisions to forgo treatment and assisted suicide. Consequently, Congress, the States, and public health care facilities would be compelled to fund and provide assisted suicide services if they continue to fund hospice care or other similar services.[3] Moreover, if assisted suicide were

[3] Your amici note that comprehensive legislation has been introduced in both the U.S. House and Senate for consideration next term that would ban the use of federal funds in any and all federal programs for assisted suicide, euthanasia, or mercy killing. *See* H.R. 4149 and S.2108 ("Assisted Suicide Funding Restriction Act of 1996"). The proposed Act was introduced by Rep. Hall (D. Tex.) with 118 additional original [footnote continued next page]

a treatment "right", then federal law would compel Medicaid and Medicare providers to assure that information on its exercise be disseminated to patients, staff, and the community. *See* 42 U.S.C. § 1395cc(f); 42 U.S.C. § 1396a(w).

In upholding a uniformly applicable federal ban on the distribution of certain drugs, this Court noted that "Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of panaceas that inventive minds can devise." *United States v. Rutherford*, 442 U.S. at 558. If Congress can ban distribution of a drug purported to cure cancer and preserve life, then surely the States may prohibit distribution of drugs and devices to the terminally ill for the purpose of ending life.

[continued from previous page] co-sponsors in the House; it was introduced by Sen. Ashcroft (R. Mo.) and Sen. Dorgan (D. N.D.) with 17 original co-sponsors in the Senate. 142 Cong. Rec.H11,047 (daily ed. Sept. 24, 1996); 142 Cong. Rec. S11,169; S11,175-77 (daily ed. Sept. 24, 1996). Under the rationales of both the *Quill* and *Compassion* courts, the Act would unconstitutionally discriminate on the basis of the manner chosen to "hasten death" if Congress continues to fund hospice and other similar forms of care.

Neither lower court acknowledged that there is any constitutionally cognizable distinction between assisting in suicide and forgoing life-sustaining treatment or providing pain relief that may shorten life as an unintended consequence. However, the Act specifically distinguishes between these categories:

> Sec. 3. Rule of Construction. Nothing in this Act, or in an amendment made by this Act, shall be construed to create any limitation relating to -- (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

III. RECOGNITION OF A DUE PROCESS LIBERTY OR EQUAL PROTECTION RIGHT TO ASSISTED SUICIDE WOULD RESULT IN NONVOLUNTARY KILLING OF PERSONS DEEMED TO HAVE A DIMINISHED QUALITY OF LIFE.

The courts below purport to restrict the right or liberty they recognize to presently competent, consenting adults with terminal conditions. *Quill*, 80 F.3d at 718; *Compassion*, 79 F.3d at 793-94. Any such limitation is illusory. The reasoning of both courts and the precedents on which they rely dictate that any right to assisted suicide must be recognized for incompetent persons and those without terminal conditions as well. Moreover, persons seeking assisted suicide as a result of mental or emotional illness will not be protected against their self-destructive impulses or provided treatment because their right to assisted suicide will eclipse their need for mental health care.

A. *The Reasoning of the Courts Below Extends Their Holdings to Sanction Nonvoluntary Killing of Persons Deemed to Have an Insufficient Quality of Life.*

In finding a liberty to assisted suicide, the *Compassion* court emphasized that, "[W]e should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." 79 F.3d at 832 n.120. The court thus explicitly expands the boundaries of the assisted suicide liberty to include incompetent persons who will be killed not by their own consent, but by the consent of a third party — whether appointed by the affected person, by a court, or by operation of law. Constitutional immunity would extend to the surrogate's decision as if it were the decision of the affected person.

The *Compassion* court's conclusion in this regard is fully consistent with its construction of this Court's decision in *Cruzan*, which it interpreted as finding a "liberty interest in

hastening death" for incompetent, non-terminally ill persons. *Compassion*, 79 F.3d at 816, 816 n.69. For additional support, the *Compassion* court invoked state statutes that provide formalities to authorize forgoing life-sustaining treatment from incompetent persons both with and without terminal conditions. *Id.* at 831.

Similarly, although the *Quill* court purports to restrict the right to competent, consenting adults, it supports its holding by citing exclusively to cases that involved incompetent persons. 80 F.3d at 727-28, *citing In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) (involving a never-competent person); *In re Eichner, id.* (decided with *In re Storar*) (involving person who had become incompetent); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986) (involving involuntarily committed mental patients); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (involving person who had become incompetent). Indeed, the core rationale of the *Quill* court — that assisted suicide must be permitted whenever life-sustaining treatment may be forgone — necessarily subsumes provision of assisted suicide to incompetent persons. The New York statutes that sanction forgoing treatment, which the court says the right to assisted suicide must mirror, specifically apply to incompetent patients. *See Quill*, 80 F.3d at 727-28. Moreover, since all persons may refuse life-sustaining treatment under New York law whether or not they are terminal, the *Quill* right to assisted suicide must logically be extended to everyone.

Thus, both lower courts contemplate extension of the right or liberty to assisted suicide to incompetent, non-terminally ill persons. Your amici have no need to resort to a "slippery slope" argument to demonstrate the calamitous consequences that would flow from their rationales, especially for persons with mental disabilities. Simply put, recognition of a constitutional right to "hasten death" under sway of either decision would sanction nonvoluntary killing of incompetent persons in the name of Fourteenth Amendment guarantees.

B. *The Treatment Refusal and Abortion Law On Which The Courts Below Rely Would By Analogy Sanction Administration of Assisted Suicide to Incompetent Persons Without Terminal Conditions.*

The courts below rely on treatment refusal and abortion caselaw as analogous precedent for the right or liberty to assisted suicide. When placed into either of these existing jurisprudential frameworks, assisted suicide must be provided to incompetent persons and persons without terminal conditions.

1. Treatment Refusal Law

State courts have generally ruled that "'[a]n incompetent's right to refuse treatment should be equal to a competent's right to do so.'" *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987), *modified*, 757 P.2d 534 (1988), *quoting In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 744 (1983). They have held that third parties must be permitted to exercise the right to refuse on behalf of incompetent persons. As the Kentucky Supreme Court noted in *DeGrella v. Elston*, 858 S.W.2d 698, 706 (Ky. 1993), "In all but two states, Missouri and New York, even when the court has been unable to precisely determine the express wishes of the patient, it has allowed the patient's family, or the patient's guardian, to exercise substituted judgment as to what the patient would wish."

Authority to refuse life-sustaining treatment for incompetent persons has been variously imputed to guardians, reserved by courts, and provided to a statutory succession of decisionmakers in at least thirty-nine jurisdictions by way of caselaw, statute, or both. *See* Thomas J. Marzen, *et al.*, *"Suicide: A Constitutional Right?" — Reflections Eleven Years Later*, 35 Duquesne L. Rev. 261, 279 n.58 (1996) (Special Issue) (citing to cases and statutes).

These authorities empower a surrogate to make life and

death decisions for a person, although the surrogate was *not* appointed by the person (in contrast to a surrogate appointed through a durable power of attorney for health care). The surrogate's decision may be based on an assessment the patient's "best interest" or through a "substituted judgment" in which the surrogate surmises the wishes of the patient. Both forms of decisionmaking may obviously involve vagaries, subjective elements, and bias that more or less dominate depending on just how much is known or can be adduced about what the person would have wanted if competent. In many, if not most cases, the decision will be based on little more than the surrogate's judgment as to whether the affected person's quality of life merits continued provision of life-sustaining treatment or care. In many or most cases, it certainly cannot be said that the surrogate's decision directly reflects the informed decision that the affected person would have made if able to do so.

When assisted suicide is poured into this body of law, surrogates will be empowered to select this "treatment option" for their wards or principals just as they may presently choose to refuse life-sustaining treatment on their behalf. Nothing in the precedents or plain language of either lower court decision suggests that it could or should be otherwise. Whether the lethal agent is self-administered or administered by another is irrelevant: Providing a lethal drug to an incompetent person to ingest is legally indistinguishable from administering a lethal injection because the victim is unable to consent in either case.

Moreover, exercise of the right to refuse treatment "does not depend upon the nature of the treatment refused or withdrawn; nor is it reserved to those suffering from terminal conditions." *Thor v. Superior Court of Solano*, 5 Cal. 4th 725, 21 Cal. Rptr. 2d 357, 855 P.2d 375, 387 (Cal. 1993) (en banc). If the right or liberty to assisted suicide is deemed equivalent to the right to refuse treatment, then its exercise plainly cannot be limited to circumstances in which a person has a "terminal condition". Nor is the authority of surrogates

generally limited either in caselaw[4] or by statute. For example, the District of Columbia's statute authorizing substituted consent provides that a succession of surrogates "shall be authorized to grant, refuse of withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment, or procedure..." D.C. Code § 21-2210 (Michie 1989 & Supp. 1995). If assisted suicide is simply to be another sort of "treatment" or "procedure" for incompetent patients, then statutory surrogates would be authorized to choose it for their wards and principals.

Indeed, ordering assisted suicide might be deemed the duty of the surrogate in some circumstances. For example, the Washington Supreme Court in *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1375 (Wa. 1984) (en banc), held that a legal guardian "has the duty" to assert an incompetent ward's "right" to refuse medical intervention when this is deemed to be in the ward's best interests. *See also In re Drabick*, 200 Cal. App. 3d 185, 205, 245 Cal. Rptr. 840, 853, *cert. denied sub nom. Drabick v. Drabick*, 488 U.S. 958 (1988). Since both the *Compassion* and *Quill* courts equate assisted suicide with refusal of treatment, unwilling guardians or other surrogates may likewise be compelled to order assisted suicide for their wards or principles or be removed as decisionmakers for failure to act in their "best interests".

2. Abortion Law

Like treatment refusal, access to abortion cannot be limited to competent, consenting adults. "[E]very pregnant minor is entitled . . . . to receive an independent judicial determination that she is mature enough to consent [to an

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[4]Thus, the right has been exercised by and behalf of persons with various non-terminal disabilities. *See, e.g., Thor v. Superior Court of Solano*, 855 P.2d 375 (Cal. 1993) (quadriplegia); *In re Colyer*, 660 P.2d 738 (1983) (persistent unconsciousness); *Bartling v. Superior Court of Los Angeles*, 209 Cal. Rptr. 220 (Cal. App. 1984) (various respiratory and other problems); *Bouvia v. Superior Court of Los Angeles*, 225 Cal. Rptr. 297 (Cal. App. 1986) (quadriplegia); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (quadriplegia).

abortion] or that an abortion would be in her best interests." *Bellotti v. Baird*, 443 U.S. 622, 649, 651 (1979). Like minors, other incompetent persons have a right to abortion.[5] If the right or liberty to assisted suicide is analogous to the abortion liberty, as the lower courts have held, then it follows that assisted suicide must be provided to immature minors and incompetent adults when it is deemed in their "best interest".

The State may restrict access to abortion when the fetus is viable in order to protect its compelling interest in fetal life at this stage of development. But no similar conflict exists between a right to "hasten one's own death" and a competing state interest in protecting the life of another in the context of assisted suicide. Thus, if assisted suicide is recognized as a right analogous to the abortion liberty, then the logic of abortion precedent would dictate that there could be no limitation based on the medical status, such as "terminal condition", of the person who seeks suicide assistance.

C. *Recognition of a Liberty or Right to Assisted Suicide For Persons With Terminal Conditions Would Irrationally Abolish the Presumption in Anti-Suicide Laws That Suicidal Persons Are Mentally or Emotionally Ill, Resulting in Nonvoluntary Killing of Many Such Persons.*

Laws that warrant suicide intervention and prevention measures now rest on the presumption that "suicide or attempted suicide is an expression of mental illness," and repre-

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[5]*See, e.g., In re Jane A.*, 36 Mass. App. Ct. 236, 629 N.E.2d 1337, 1338 (1994) (authorizing substituted judgment decision of temporary guardian to abort child of ward with mental retardation); *In re Moe*, 31 Mass. App. Ct. 473, 579 N.E.2d 682, 687 (Mass. 1991) (authorizing substituted judgment decision of guardian to abort child of ward with mental retardation, giving weight to preference of ward); *In re Doe*, 533 A.2d 523, 526 (R.I. 1987) (authorizing substituted judgment decision of guardian to abort child of ward with mental retardation over objection of ward's mother).

sents a plea for help and the need for psychiatric treatment. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 64 (Cal. App. 2 Dist. 1992). This presumption forms the basis of our civil commitment laws[6] and laws allowing the use of nondeadly force to thwart suicide attempts. *See, e.g.*, Alaska Stat. § 11.81.430(a) (1993); Haw. Rev. Stat. § 703-308(1) (1993); Or. Rev. Stat. § 161.209 (1993).

However, a holding that persons with "terminal conditions" have a constitutionally recognized right or liberty to assisted suicide would necessarily abolish the presumption for this class of persons. The State could no more presume that a terminally ill person seeking assisted suicide has a mental or emotional illness than it could presume that a woman seeking an abortion or any person refusing life-sustaining treatment is mentally or emotionally ill because they seek to exercise the right.

As a consequence, many suicidal persons with undiagnosed mental or emotional illnesses would die from preventable suicide. They would not and could not be treated the same as other suicidal persons. Because they propose to exercise a constitutional right, the State could not subject them to evaluation, treatment, civil commitment, or any other form of intervention to prevent suicide without first demonstrating an exceedingly compelling justification. Statutes permitting suicide intervention would be subject to challenge as applied to the terminally ill on the grounds that they burden the exercise of a fundamental right.

Suicidal persons with terminal conditions are, however, clinically indistinguishable from suicidal persons without terminal conditions. "[L]ike other suicidal individuals, patients

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[6]*See, e.g.*, Alaska Stat. § 47.30.700 (1993); Ariz. Rev. Stat. Ann. § 36-533(A)(1) (1993); Cal. Welf. & Inst. Code §§ 5200, 5201, 5213 (West Supp. 1993); Haw. Rev. Stat. § 334-60.2(2) (1993); Idaho Code §§ 66-317(M), 66-324 (1994); Mont. Code Ann. §§ 53-21-102, 53-21-121 (1993); Nev. Rev. Stat. Ann. § 433A.310(1) (Michie Supp. 1993); Or. Rev. Stat. §§ 426.005(1)(d)(A), 426.060(2) (1994); Wash. Rev. Code Ann. § 71.05.010(2) (West 1993).

who desire an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly a depressive condition." Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 143, 143 (1993); Tia Powell & Donald B. Kornfeld, *On Promoting Rational Treatment, Not Rational Suicide*, 4 J. Clin. Ethics 334, 334 (1993). Abolition of the presumption of mental or emotional illness for suicidal person with terminal conditions would thus be inconsistent with psychological fact.

It is undisputed that the State has a strong interest in preventing suicide. *Addington v. Texas*, 441 U.S. 418, 427 (1979) ("The state has a legitimate interest under its parens patriae powers in providing care to its citizens who...pose some danger to themselves.") As the Arizona Supreme Court observed, "[I]t would be illogical indeed to suggest that the state's interest in preventing suicide magically disappears only when an individual becomes terminally ill and completes certain paperwork." *Rasmussen v. Fleming*, 741 P.2d at 674, 685 (Ariz. 1987). This Court has observed that the State's interest in suicide prevention prevails even against claims based on the First Amendment's protection of free exercise of religion. *Reynolds v. United States*, 98 U.S. 145, 166 (1878); *Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States*, 136 U.S. 1, 49-50 (1890).

Moreover, when persons expressly declare their suicidal intent, the state's interest in the protection of life has been held to be overriding. See *Donaldson*, 4 Cal. Rptr. 2d at 63 (state's interest in preventing suicide "overrides any interest [that person with terminal condition] possesses in ending his life"); *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984) (in view of "specific intent of causing... death..., the State's interest in preserving life and preventing suicide dominates"); *In re Von Holden*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 625-26 (1982) (and the cases there cited) ("It is self-evident that the right to privacy does not include the right to commit suicide... To characterize a person's self-destructive acts as entitled to that Constitutional protection would be ludicrous... The preserva-

tion of life has a high social value in our culture and suicide is deemed a 'grave public wrong'.... [T]he case law of our sister states indicates the universality of that principle.")

IV. A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES EXCLUSION OF PERSONS WITH TERMINAL CONDITIONS FROM EQUAL PROTECTION OF STATE LAWS BANNING ASSISTED SUICIDE WOULD VIOLATE CONGRESSIONAL POLICY EXPRESSED THROUGH THE AMERICANS WITH DISABILITIES ACT.

A holding by this Court that persons with "terminal conditions" may not, as a matter of constitutional law, be provided equal protection of state assisted suicide bans would conflict with Congressional policy forbidding discrimination by public entities on the basis of disability as expressed through the Americans with Disabilities Act of 1990 ("ADA"). Pub. L. No. 101-336, 104 Stat. 327 (codified at 42 U.S.C. §§ 12101-12213 and 47 U.S.C. § 225, 611). The ADA itself provides that people with disabilities are "a discrete and insular minority" who have "been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness". 42 U.S.C. § 12101(a)(7). In enacting the ADA, "Congress considered disability classifications to be just as serious and just as impermissible as racial categorizations". Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 Temple L. Rev. 393, 434 (1991); *see also* Amy Scott Lowndes, Note, *The Americans with Disabilities Act of 1990: A Congressional Mandate for Heightened Judicial Protection of Disabled Persons*, 44 Fla. L. Rev. 417 (1992) (discrimination on the basis of disability constitutes Congressionally-mandated "suspect classification"). Presumably, this Court would not permit the State to legislate a race-based exclusion to the protection of assisted suicide bans — much less contemplate creating a constitutionally mandated, race-based exclusion to such bans. In light of the ADA, neither should it create an exclusion based on the disability of a "terminal condition".

Under the ADA, a "disability" is any "physical or mental impairment that substantially limits one or more of the major life activities of [an] individual." 42 U.S.C. § 12102; *see also* Interpretive Guidelines on Title I of the ADA, 29 C.F.R. app. § 1630.2(j) (whether limitation is "substantial" is determined by the impairment's nature and degree, its expected or actual duration, and its permanence or long-term impact). Plainly, any genuinely terminal condition thus qualifies as a "disability" under the ADA. *See In re Baby K*, 832 F.Supp. 1022, 1028-1029 (E.D. Va. 1993), *aff'd on other grounds*, 16 F.3d 590 (4th Cir. 1994), *rev. denied sub nom. Baby K v. Ms. H*, __ U.S. __, 115 S. Ct. 91 (1994) (denial of life-sustaining ventilator on the basis of anencephalic disability violates ADA).

The ADA prohibits actions by or policies of public entities that "exclude from participation in" or "deny the benefits of" any program, service, or activity of the public entity or by which persons are "subjected to discrimination by any such entity." 42 U.S.C. § 12132 (1995). As public entities, the States are thus obliged to afford the same treatment to suicidal persons with terminal disabilities as it does to others in its laws and programs. A decision that would compel the State to treat those with terminal conditions differently under its laws and programs intended to protect against or prevent suicide or assisted suicide would thus run counter to the ADA.

If assisted suicide were recognized as a right for competent persons able to commit suicide by themselves, however, then the ADA would require that direct lethal means must be permitted for persons who, due to disabilities, are unable to kill themselves. Otherwise, persons whose disabilities render self-killing impossible would be "exclud[ed] from participation in" and "den[ied] the benefits of" assisted suicide solely because of disability. In sum, the ADA would require that homicide be allowed for otherwise qualified persons who, because of disability, are unable to kill themselves.

The ADA also provides that "[n]othing in this Chapter

shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept." 42 U.S.C. § 12201(d) (1995). Persons with terminal conditions would have no choice but to accept inferior assisted suicide protection and prevention services in a regime inspired by a holding that discounts the state's interest in protection of their lives.

In any case, conflict with the ADA cannot be avoided by claiming that recognition of a right or liberty for the terminally ill would merely present them with a unique "choice" to decline the "benefits" of state suicide prevention and protection policies that is not accorded to others. It might just as easily be claimed that a policy that allowed only members of a certain race to waive equal protection of state assisted suicide bans and suicide prevention programs simply offers to that race the "benefit" or "accommodation" of assisted self-killing. Such a race-based exclusion would plainly be rejected by this Court — just as it should likewise reject the disability-based exclusion that recognition of a constitutional right or liberty to assisted suicide for the terminally ill would create.

The anti-discrimination policy embodied in the ADA would be undermined by any constitutional rule that mandated the State to treat persons with terminal conditions differently than others in assisted suicide and suicide prevention law and policy. A decision recognizing such a rule would, in effect, declare that death is a "benefit" for this class of persons with disabilities, while it remains a harm for all others. It would warrant the "most pernicious discriminatory bias against the disabled that one can imagine...in the name of the disabled's right to die." Laurence H. Tribe, *American Constitutional Law* 1598-1599 (1988).

CONCLUSION

Your amici pray this Court to reverse the decisions of the lower courts and to reject the claim of a constitutionally protected liberty or right to assisted suicide.

Respectfully submitted,

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Petitioner,

vs.

TIMOTHY E. QUILL, M.D., et al.,

Respondent.

and

STATE OF WASHINGTON, et al.,

Petitioner,

vs.

HAROLD GLUCKSBERG, M.D., et al.,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Second Circuit And To The United States Court Of Appeals For The Ninth Circuit

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STATEMENT OF INTEREST

The Evangelical Lutheran Church in America [ELCA] is the largest Lutheran denomination in North America and the fifth largest Protestant body in the United States. It has approximately 11,000 member congregations which in turn have approximately 5.2 million members. As part of its mission, the ELCA supports twenty-eight colleges, eight theological seminaries, 400 missionaries in 50 countries, 450 chaplains in the armed forces, and 260 social service institutions, including hospitals, hospices, long-term care and residential facilities for older persons, and facilities for adults, youth and children with special needs.

The ELCA began its official existence January 1, 1988, as a merger of three predecessor bodies: The Lutheran Church in America [LCA], the American Lutheran Church [ALC] and the Association of Evangelical Lutheran Churches [AELC]. These groups trace their history in this country to the seventeenth century and in Europe to the Reformation in Germany. For deeply religious reasons, Lutherans view the human condition as flawed and broken, sustained only by the grace of God. In a century marked with wars, racism, genocide and other massive evil, secular decision-makers have ample evidence to distrust the rosy picture of inherent human goodness and generous human compassion offered as the predicates for the decisions below.

The guiding principles for specific positions of the ELCA on issues of social ethics are contained in its own social statements and in those of its predecessor church bodies. Task force reports support these statements and messages draw out their implications. Three such documents are directly relevant to the issues discussed in this brief: the 1992 Message of the ELCA on End-of-Life Decisions, a 1982 Social Statement on Death and Dying adopted by the Eleventh Biennial Convention of the LCA, and a paper issued in 1977 by the ALC's Task Force on Ethical Issues in Human Medicine.

The 1992 ELCA Message, appended to the brief as Appendix A, states: "The integrity of the physician-patient

relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death. However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. . . . We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased." App. 5-6.

The 1982 LCA Social Statement states: "Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter [from refusing treatment]. This is frequently called 'active euthanasia' or 'mercy killing' (as contrasted with . . . withholding or withdrawing medical treatment, thereby allowing death to occur from a disease or injury). Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience. Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which elicit a renewed commitment to living."

The 1977 ALC paper states: "We affirm that direct intervention to aid the irremediably deteriorating and hopelessly

ill person to a swifter death is wrong. While direct intervention in many cases may appear 'humane,' deliberate injection of drugs or other means of terminating life are acts of intentional homicide. This deliberate act is far removed from decisions which allow people to die – like shutting off a life-support machine or even withholding medication. Permission for the normal process of death is an act of omission in the spirit of kindness and love within the limits of Christian charity and legal concerns. Direct intervention to cause death, known as active euthanasia, can not be permitted. We affirm there is a distinct moral difference between killing and allowing to die."

Letters from the parties consenting to the filing of this brief have been filed with the Clerk of this Court pursuant to Rule 37.3.

SUMMARY OF ARGUMENT

The homicide laws in all of the states prohibit the purposeful, knowing, reckless or negligent killing of another human being. About two-thirds of the states also expressly prohibit assisting or aiding suicide. All of these criminal bans refuse to recognize the consent of the victim as a defense. The two lower courts reviewed in these cases have ruled that the federal constitution *requires* the States to abandon this effort to surround human life at a most vulnerable point with that protection.

The lower courts offer a naively optimistic promise that a regime of physician-assisted suicide would protect the values of liberty and equality. The Ninth Circuit found a liberty interest in the Due Process Clause of the Fourteenth Amendment that would nullify a Washington statute prohibiting physician-assisted suicide. The methodology of substantive due process is ill-suited for grounding a constitutional right to suicide, let alone a right to involve the medical profession in administering lethal poison to kill another person. The Due Process Clause has been used to require that all states protect substantive liberties such as free exercise of religion, freedom

of speech, and freedom of the press. It has never been used to allow the direct intentional killing of another or providing the means of ending life to another person. The Court should not invoke substantive due process to repudiate the constant teaching of the common law that the human person is free to refuse medical treatment, but that a State may reasonably prohibit all persons, including physicians, from acting affirmatively to end human life. The line we insist should be maintained between killing a person and allowing a person to die might not always be perfectly clear, but over a long period of time it has been vastly more effective at preventing abuse than the slippery standards offered by the Ninth Circuit. A regime of physician-assisted suicide would actually exalt physician control over patients and would thus radically undermine personal freedom.

The Second Circuit nullified a similar New York statute as a violation of the Equal Protection Clause. There is no fundamental right to take one's own life, let alone a right to assistance by a physician in ending one's life. Hence New York has a rational basis for maintaining its prohibition of physician-assisted suicide. New York recently completed a lengthy and exhaustive study culminating in a comprehensive report unanimously rejecting the adoption of physician-assisted suicide. The New York report concluded that the regime of physician-assisted suicide in the Netherlands had resulted in massive involuntary euthanasia, and it unanimously repudiated a practice that it legitimately equated with radical undermining of its commitment to equality of all persons, especially older persons, the poor, and those with disabilities. A state is entitled to considerable deference in choosing among policy alternatives. That traditional deference is heightened where the state is acting to fulfill its solemn duty to protect life and to express special concern for the most vulnerable among us.

Both lower courts trivialize the enormous complexity of the issues underlying the social experiment they find imbedded in the Fourteenth Amendment. They make unfulfillable

promises, and they grossly underestimate the peril to liberty and equality inherent in a scheme of physician-assisted suicide.

ARGUMENT

I. Preserving the distinction between killing a person and allowing a person to die protects personal liberty; a regime of physician-assisted suicide does not.

A. The distinction between killing a person and allowing a person to die is well grounded in the common law.

These cases implicate the deepest philosophical concerns about the nature and destiny of the human person. The traditions of this nation have for centuries preserved a delicate balance between individual responsibility and the communal dimension of human life. Each of us is precious and unique, born into communities that support us and shape our very existence: families, religious communities, neighborhoods, cities, states, and the nation itself. By radically transforming the meaning of the fundamental values of liberty (Part I) and equality (Part II), these cases threaten to do irreversible damage to that balance between the individual and the community.

For over two millennia physicians have served their patients with an understanding that their duty was to heal and to support human life in all circumstances. *See* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 330 (4th ed. 1994) (citing the Hippocratic Oath, with its promise "to do no harm"). This duty corresponds to a communal concern to protect the health and well-being of the human person.

The common law also preserved a delicate balance between the individual and the community by acknowledging that a competent person can decline medical treatment. See *Mills v. Rogers*, 457 U.S. 291, 294 note 4 (1982); W. Keeton, *Prosser and Keeton on the Law of Torts* § 18, at 116-19 (5th

ed. Supp. 1984). Indeed, physicians committed common-law torts if they did not first obtain their patients' informed consent. While Justice Cardozo was a judge on the New York Court of Appeals, he wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). *See also Natansen v. Kline*, 186 Kan. 393, 350 P. 2d 1093, 1104 (1960); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905). These cases refer to the right to protect the integrity of one's body from intrusion, and not to any purported right to consent to be killed. Under the common law of battery, then, physicians may allow a patient to die by respecting that person's lack of consent to continuing medical treatment. Aiding such a person's death by causing a bodily intrusion, on the other hand, is clearly a tortious battery whether or not the person consents. *Id.*

Similarly, the criminal law of all the states prohibits the killing of another, even where the victim consents. Withdrawing medical treatment, on the other hand, is not killing and therefore not criminal because it is viewed as an omission by the physician where the patient or appropriate surrogate has elected to decline further medical treatment. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). This distinction is the legal analogue to the ethical teaching of the ELCA referred to above in the statement of interest, concerning the distinction between killing a person, which we view as highly immoral, and letting a person die, which we acknowledge can be ethically permissible, at least under some circumstances.

B. There is no substantive liberty interest in taking one's life, much less in having a physician "assist" in this process.

Against this clear teaching of the common law of torts and crimes, we assess the constitutional provision relied upon by the Ninth Circuit for its conclusion: "No State shall deprive any person of . . . liberty without due process of law. . . . " U.S. Const. Amend. XIV. This clause obviously cannot mean that no state may ever restrict the liberty of any of its citizens. All of the states do that all the time by a variety of regulatory schemes that frequently entail fines or other penalties that amount to deprivations of liberty. The primary safeguard referred to by the Due Process Clause is obviously procedural. But this Court has also relied upon this clause to ensure that all of the states would protect fundamental liberties with at least as much care as is required of the national government.[1]

The extent to which a right might be regarded as immune from state regulation or prescription is not absolute, but may vary according to the nature of the right and the context within which it is asserted. Examples of liberty interests that this Court has protected under the Due Process Clause against state regulation include freedom of speech, *Gitlow v. New York*, 268 U.S. 652 (1925); freedom of the press, *Near v. Minnesota*, 283 U.S. 697 (1931); and freedom of religion, *Cantwell v. Connecticut*, 310 U.S. 696 (1940). As high as these fundamental liberties rank in our constitutional order, *Thomas v. Collins*, 323 U.S. 516, 530 (1945), *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 303 (1943), they do not mean that everyone invoking them is automatically guaranteed that he or she is free from the burden of reasonable governmental regulation. This outcome is determined by

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[1] The states are clearly free to surround human liberty with greater protection or more specific safeguards than is required by the federal Bill of Rights. *See, e.g., PruneYard Shopping Center v. Robins*, 447 U.S. 74 (1980).

a careful examination of the factual context within which a right is asserted, and by the adherence of the government to standards governing its own conduct. Despite Justice Black's persistent view in the absolute character of free speech, *The Bill of Rights*, 35 N.Y.U.L.Rev. 865 (1960), this Court has never thought to invalidate the libel laws of all fifty states. Despite the vital significance of a free press in a free and open society, *New York Times v. United States*, 403 U.S. 713 (1971), this Court has never held that this freedom gives the press greater access to governmentally held information than that enjoyed by the general public. *See, e.g., Saxbe v. Washington Post*, 417 U.S. 843 (1974); Stewart, *Or of the Press*, 26 Hastings L. J. 631 (1975). Or, to illustrate the varying content of parental liberty secured under substantive due process, *Pierce v. Society of Sisters*, 268 U.S. 510 (1926), invalidated a provision of the Oregon constitution that required all children to attend schools operated by the government, but *Pierce* emphatically does not mean that the states must abandon their truancy laws. *Meyer v. Nebraska*, 262 U.S. 390 (1923) invalidated a statute prohibiting the teaching of the German language, but *Meyer* does not mean that the states or the thousands of local school districts are required to teach German or otherwise lack broad discretion to regulate the content of the educational curriculum, at least in the schools they operate.

The relative character of rights subsumed under the Due Process Clause is directly relevant, even critical, to the analysis of these cases. The Ninth Circuit explicitly recognized this approach, yet its opinion is a classic example of careless expansion of this Court's treatment of substantive due process. Taken along the natural trajectory of its logic, the approach of the Ninth Circuit would for all practical purposes mean that no State may restrict the liberty of any of its citizens on this matter, including those who are depressed or simply tired of living. This conclusion is clearly at odds with the text of the Due Process Clause and with the history of its interpretation by this Court. Worse yet, this approach would

nullify the sovereign obligation of the several states to protect life, a duty that is demonstrably clear in the text of the same provision: "No state shall deprive any person of *life* . . . without due process of law."[2]

Reflecting considerable restraint, this Court's general standard for reviewing substantive due process claims is deferential to legislative judgments, unless they impinge upon fundamental rights. The Ninth Circuit explicitly acknowledged that the right it sought to protect is not "fundamental" in the sense that it is so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Curiously, however, the Ninth Circuit concluded that Washington has no legitimate interest in prohibiting physician-assisted suicide.[3]

The Second Circuit expressly rejected the substantive due process claims pressed in these cases, No. 95-1858, Pet.

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[2] This issue is now before the Ninth Circuit in an appeal from the decision of a district court enjoining a provision in the Oregon constitution recently enacted by initiative. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), on appeal sub nom. *Lee v. Harcleroad* (9th Cir. Nos. 95-35804, 95-35805, 95-35854, 95-35948, and 95-35949). The ELCA joined an amicus brief in *Lee* urging that life is an inalienable fundamental right that may not be "waived" by any class of citizens.

[3] The Ninth Circuit formally recognized that "State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests." No. 96-110, Pet. App. A-102. But this language is not reliable as a guide to the lower court's own decision, for the court went to great lengths to dismiss every state interest that might justify judicial restraint as illegitimate or irrelevant. *Id.*, A-65 to A-101. Still less is the Ninth Circuit's opinion reliable as a prediction of the likely outcome in a regime of physician-assisted suicide. In the Netherlands the very categories relied upon by the Ninth Circuit as safeguards against abuse – limiting assisted suicide to cases where the patient is competent, voluntarily opts for death, is terminally ill, and is suffering, and limiting the persons who may offer such assistance to doctors – all broke down within years of the relaxation of the legal standards governing the ending of human life. See 22-23 below.

App. 16a-20a, noting that this Court stated in *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986), that it is not "inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause." According to the Second Circuit, "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those who, in the final stages of terminal illness, seek the right to hasten death." No. 95-1858, Pet. App. 19a. The Second Circuit further noted the Court's reluctance "to expand the concept of substantive due process because guideposts for responsible decisionmaking in this uncharted area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). And the Second Circuit concluded: "Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area." No. 95-1858, Pet. App. 20a. For the reasons set forth above, we urge the Court not to find a new right to physician-assisted suicide in the Due Process Clause, but to allow the States to maintain a prohibition of physician-assisted suicide and to sustain a distinction – well grounded in the common law of torts and crimes – between killing a person and allowing a person to die.

C. Misguided reliance upon *Cruzan*

The Ninth Circuit relied on *Cruzan v. Director of Missouri Department of Health*, 497 U.S. 261 (1990). No. 96-110, Pet. App. A-58 to A-62. In *Cruzan* this Court considered whether the Fourteenth Amendment protected a liberty interest of a patient to refuse or to terminate medical treatment, even if it meant the patient would die. The Court held that the State could impose a stringent evidentiary standard to prove that an incompetent patient, while competent, had expressed a desire to have life-saving medical treatment terminated. In the process of the decision, a majority of the justices seemed to accept a right of a competent patient to

terminate medical treatment, even though it would clearly hasten death.

The extreme conclusion reached by the Ninth Circuit is not required by the majority opinion in *Cruzan*. Indeed, nowhere in all of the opinions in *Cruzan* did any member of this Court ever intimate the view ascribed to the Court by the Ninth Circuit in this case. *Cruzan* can be read as protecting a right to refuse medical treatment, *see Cruzan*, 497 U.S. at 269-80, or more narrowly as an evidentiary ruling sustaining a state's imposition of the clear and convincing evidence standard when this right is invoked as life nears its end, *id.* at 280-85, and at 292 (O'Connor, J., concurring). But *Cruzan* cannot be read as holding that the Due Process Clause protects an unqualified liberty interest of a person to suicide, much less that a dying patient has a right to involve physicians in acting against the centuries-old tradition reflected in the Hippocratic oath. To argue that the right to be free from medical intervention includes an affirmative right to assistance in dying flies in the face of the very limited language in *Cruzan*. The Ninth Circuit's view is also contrary to cases in which this Court has held that there is no right to state provision of assistance, even as to conduct the Court has found constitutionally protected. *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); *Beal v. Doe*, 432 U.S. 438 (1977).

Both before and after *Cruzan*, several commentators have recognized the importance of drawing a clear line between killing and letting die, because this distinction offered courts an objective standard that would enable them to recognize the right to refuse certain medical treatment without also recognizing a right to suicide or euthanasia. *See, e.g.*, Lawrence H. Tribe, Governmental Control Over the Body: Decisions About Death and Dying, *American Constitutional Law* § 15-11, p. 1365 (2d ed. 1988); Mark Chopko and Michael Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 520, 564-67 (1995).

D. Misguided reliance upon *Casey*

The Ninth Circuit also relied on language in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992). No. 96-110, Pet. App. A-56 to A-58. In reaffirming a person's liberty interest in controlling intimate and personal decisions about abortion, Justices O'Connor, Souter, and Kennedy wrote in *Casey*: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 112 S. Ct. at 2807. The Ninth Circuit cited this statement in *Casey*, Pet. App. A-56, and drew from it the conclusion that when patients are in great pain, they have a similar liberty interest not only to hasten their death rather than continue to live in pain, but also to implicate the medical profession in this choice. Pet. App. A-57 to A-58.

This analysis is seriously flawed. This court in *Casey* spoke only about a constitutionally grounded right to liberty in the context of defining the future and ongoing living of a life. This language should not be removed from the context of living to the context of death, where its meaning lies beyond all of us. The Court intimated no views whatever about a constitutionally grounded right to die. *See* Chopko and Moses, *Assisted Suicide, supra*, 70 Notre Dame L. Rev. 520, 558-64. The language from *Casey* cited above should not be removed from the context in which it was uttered. As Judge Noonan noted in the original panel decision in the Ninth Circuit, "It is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context. To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to

find these sentences 'almost prescriptive' in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request." No. 96-110, Pet. App. D-11.

E. The Impossibility of Establishing Reliable Criteria for Limiting Physician-Assisted Suicide

The inappropriateness of expanding the language in *Casey* cited above to the question presented in these cases is confirmed by focusing on the illusory nature of the lower court's attempt to confine the new right to physician-assisted suicide that they have discovered in the Fourteenth Amendment.[4] The lower courts defend the creation of a constitutional right to physician-assisted suicide because they are confident that this right would operate under five carefully confined conditions. They believe that the right will be exercised only by (1) *competent patients*, (2) who *voluntarily decide to hasten death*, (3) who are *terminally ill*, (4) who *are suffering acute pain*, and (5) to whom *a physician would prescribe or provide a lethal dose of medication for the patients to take, or would actually administer a lethal dose to the patients in some circumstances*. We comment briefly on each of these categories to illustrate how unstable and unreliable they are, and to call into question the claim that a regime of physician-assisted suicide would in fact promote personal liberty.

First, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *competent* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 11a, 12a, 19a, 24a, 31a, 33a; and No. 96-110, Pet.

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[4] This section of the brief relies heavily on an article by Susan R. Martyn and Henry J. Bourguignon, *Physician Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, which will appear in 85 Cal. L. Rev. ___ (Mar. 1997). A copy of the manuscript has been served on the parties and placed in the Library of the Court.

App. A-10, A-11, A-12, A-14, A-17, A-20, A-21, A-29, A-59, A-60, A-62. This standard, however, is by no means a bright line test. Neither law nor medicine provides a simple, clear litmus test to determine patient competence. For a discussion of the complexity of the legal tests for competence, *see* John Perry, *Incompetency, Guardianship, and Restoration*, and *Decision-Making Rights over Persons and Property*, in Samuel Brakel et al, eds., *The Mentally Disabled and the Law* (1985); Thomas Gutheil and Harold Burstztjn, *Clinicians' Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings*, 143 Am. J. Psychiatry 1020 (1986); S. McCrary and A. Walman, *Procedural Paternalism in Competency Determination*, 18 Law, Med. and Health Care 108, 112 (1990). Serious illness, moreover, often requires powerful medications that can alter the patient's level of competence. So can pain and suffering, fear of an unknown future, and dependence on health-care providers. In the context of physician-assisted suicide, a patient should not be deemed competent unless he truly understands not only his medical condition, but also the health care options available to treat it, including care in alternative facilities or at home. And it would mean that alternatives to suicide be genuinely accessible to the patient. Competence in this setting is thus not easy or inexpensive to assure. Unlike other mistakes that occur around the issue of patient competence, a mistake in construing a patient's desires as a request for physician-assisted suicide is, of course, irreversibly fatal.

Second, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who *voluntarily* want to end their lives. *See, e.g.*, No. 95-1858, Pet. App. 5a, 34a; No. 96-110, Pet. App. A-9, A-10, A-11, A-12, A-14, A-17, A-18, A-20, A-21, A-49, A-65, A-75. At best, this line is elusive and treacherous.[5] If it is difficult to

[5] For example, the Ninth Circuit expressly approved nonvoluntary termination of life in the cases of incompetent patients. Pet. App. A-101, note 120.

determine whether a request for physician-assisted suicide is made by a competent patient, it is far more difficult to assure that such a choice is truly voluntary, for choice is often clouded. Many persons who request suicide are "beset with ambivalence, simply wish to reduce or interrupt anxiety or are under the influence of drugs, alcohol or intense pressure." Tom L. Beauchamp and James F. Childress, *Moral Problems of Suicide Intervention* in Tom L. Beauchamp and Robert M. Veatch, *Ethical Issues in Death and Dying* 127, 128 (1996). Further, such a person may entertain rescue fantasies. A "competent" request for suicide actually may convey a deep desire for relief from the distressing realities currently confronting the person. When this occurs, granting assistance in suicide actually disregards the patient's true intent. Edwin Ringel, *Suicide Prevention and the Value of Human Life*, in Beauchamp and Veatch, *supra*, at 144. Even if one assumes, as the Ninth and Second Circuits did, that a patient's suicide request can be truly voluntary, assessing what such a request means will often be impossible without a psychiatric evaluation. Depression, the major precursor of suicidal intent, worms its way into many serious illnesses and disabilities. And depression, especially among the elderly, often remains underdiagnosed and untreated. Given the dependence of ill persons on insurance companies and other health care providers whose motive is to maximize profits, moreover, a "right" to die could well be transformed into a duty to die imposed upon a helpless person to alleviate the burdens of rising medical costs. In this all too plausible scenario, true personal autonomy is lost when the quick way out is urged upon the patient by his doctor. It is bizarre to defend physician-assisted suicide as an exaltation of personal freedom. We call it a program of advancing the economic self-interest of large health corporations; we call it professional control over death and its discussion.

Third, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *terminally ill* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 15a, 25a; No. 96-110, Pet. App. A-9, A-10, A-13, A-14,

A-15, A-16, A-17, A-18, A-20, A-21, A-48, A-49, A-51. The timing of death, however, with its silent footsteps, often lies beyond the scientific prognostication of modern medicine. Thus state courts have noted the difficulty of defining the category, "terminally ill," with precision. "Predicting that a condition is 'terminal' within any specific time period or opining on the 'imminence' of death has been very difficult for the medical profession. . . . Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community." *Browning v. Herbert*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990). *See also* Joanne Lynn, *Caring at the End of Our Lives*, 335 New Eng. J. Med. 201 (1996) (noting that if the definition of "terminally ill" referred to persons with a 50 percent chance of living six months, most of the frail elderly in nursing homes would be considered terminally ill). Thus Judge Noonan noted accurately in No. 96-110, "The category created ["terminally ill"] is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. . . . If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it." No. 96-110, Pet. App. D-12. For a graphic example of a physician-assisted suicide involving a person who was by no means "terminally ill," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).[6] *See also* Yale

[6] According to one commentator, Kevorkian's primary goal as a pathologist has always been the use of tissue from newly dead bodies for medical experimentation. Robert A. Burt, *Choosing Death for Oneself/for Others* in Lotta Westerhill and Charles Phillips, eds., *Patient's Rights: Informed Consent, Access and Equality* 63, 80-82 (1994). Another commentator notes that medical advocates for assisted suicide like Kevorkian will be most successful with vulnerable women: Stephanie Gutmann, *Death and the Maiden*, 214 New Republic (June 24, 1996) 20-28. For example, in the case cited above, when Kevorkian assisted Janet Adkins to commit suicide, she had been diagnosed with Alzheimer's disease and feared what the disease would do to her in the future. She was 54 years old, was not in imminent danger of death, and was not suffering pain. Kevorkian did not independently confirm her diagnosis or attempt to discover whether she was depressed.

Kamisar, *"Are Laws Against Assisted Suicide Unconstitutional?"* 23 Hastings Center Report 32, 36-37 (1995).

Fourth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who are *suffering considerable pain*. No. 95-1858, Pet. App. 5a; No. 96-110, Pet. App. A-9, A-11, A-13, A-48, A-52, A-53. This assumption, however, provides no meaningful standard either. It is also misguided because it ignores the enormous progress in recent years in providing palliative care, which eases pain without curing the patient. See Derek Doyle, *The Physical Control of Pain* in Derek Doyle, ed., *Palliative Care: The Management of Advanced Illness* (1984). Today, in settings where staff has adequate training, it is now routine to control pain fairly easily in 98% of all patients, and to manage pain in those rare cases where pain control is more difficult. *See* Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474 (1996); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 N. Eng. J. Med. 1124 (1996). The very concept of "pain," moreover, is itself a fluid one that does not afford precise guidance for those who would have to administer a newly created regime of physician-assisted suicide. For a graphic example of a physician-assisted suicide involving a person who was probably depressed at the news of her diagnosis, but was not otherwise clinically "suffering pain," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).

Fifth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only in an environment where a physician would prescribe or provide a lethal dose of medication for the patients to take, or where a physician would actually administer the lethal dose to the patients in some circumstances. *See, e.g.*, No. 95-1858, Pet. App. 4a, 12a; No. 96-110, Pet. App., A-9, A-111, A-112. This line, however, is as questionable and untrustworthy as the other four, given the fact that so many in this country have no physician at all to whom they can turn for health care, let alone a physician with whom they have a personal relationship of trust. As we note below, moreover, the state may preserve the integrity of the physician's practice and the traditional role of the doctor in our society, which has been that of a healer, not of a minister of death. In our society doctors are widely recognized as professionals dedicated to delivering, restoring, saving and comforting life. Some doctors are better at this than others, but all doctors – irrespective of their technical skills or particular training – are expected to support life rather than to destroy life. In a regime of physician-assisted suicide, at least some doctors will be recognized as promoters of swift death. The ineluctable result will be that patients will not have the same trust and confidence in the advice their doctors offer. Most troubling, even a suggestion of the possibility that death might be hastened, when made by a doctor to a seriously ill, dependent and suffering patient, will force the patient to justify her remaining existence. We dare not call this "compassion." Indeed, the entire approach of the Ninth Circuit is based on a total misunderstanding of the virtue of compassion, which has to do with bonding with the other and with empathetic caring for the other, not with directly intending to cause the death of the other.

The supposed protections offered by the lower courts turn out to provide an insecure, elusive and deceptive line of defense against abuse. Asserting that only competent, terminally ill patients who voluntarily choose to end their lives because of their intolerable pain will be granted the assistance

of a doctor in ending their lives, is a claim that no legal system can guarantee, a line no court can enforce. If this Court creates a constitutional regime of physician-assisted suicide, even if the patient who is helped to die was not competent to make the decision, or even if the patient's decision was not fully voluntary, or even if the patient was not terminally ill, or even if the patient did not suffer from intolerable and unrelievable pain, or even if the aid in dying was not given by a physician – there will seldom if ever be a successful prosecution. Many will die; few seriously ill persons will be protected.

None of the five elements discussed above is a reliable criterion for a stable constitutional test that would ensure that physician-assisted suicide will be cabined in a manner that would enhance personal liberty. When combined into a five-part test, they do not improve as stable predictors of the future. The line protecting against involuntary euthanasia – even state-encouraged involuntary euthanasia – simply does not hold. The activity allowed by physician-assisted suicide will inevitably fail to satisfy the appetite of those who support it; they will mount unrelenting pressure to expand the limits of the permissible and to go beyond it. The journey down the slippery slope is far too risky to undertake at all, much less on the flimsy assurances against future abuse offered by the lower courts. The line we insist should be maintained between killing a person and allowing a person to die might not always be a perfectly clear line, but over a long period of time it has been vastly more effective at preventing abuse than the untenable line proposed by the lower courts.

F. Legitimate Governmental Interests in Prohibiting Physician-Assisted Suicide

As we have suggested above, to defend a regime of physician-assisted suicide under the rubric of liberty begs a very important question about whose liberty would in fact be promoted by this change. When a state preserves the distinction between killing a person and allowing a person to die, it

promotes the interest in personal liberty; a regime of physician-assisted suicide would not.

Judge Noonan identified five legitimate governmental interests that undergird the prohibition of physician-assisted suicide: (1) the interest in not having physicians in the role of killers of their patients; (2) the interest in preventing abuse similar to what has occurred in the Netherlands where the practice of allowing assisted suicide now includes direct measures taken to end a person's life without a contemporaneous request to do so; (3) the interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths; (4) the interest in protecting the poor and minorities from exploitation; and (5) the interest in protecting persons who are disabled from societal indifference and antipathy. No. 96-110, Pet. App. D-14 to D-17. We discuss the first two interests in this section of the brief because they are directly related to the theme of personal liberty, and the last three interests in Part II below because they are related to the theme of equality. In articulating these governmental interests, Judge Noonan relied on the most comprehensive study of physician-assisted suicide by a governmental body, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994).[7] We now discuss

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[7] The study was conducted by the New York State Task Force, a commission appointed by Governor Cuomo in 1985, which filed its report in May, 1994. The Task Force was composed of twenty-four members representing a broad spectrum of ethical and religious views and ethical, health, legal, and medical competencies. Its membership disagreed on the morality of suicide. Unanimously the members agreed against recommending a change in New York law to permit assisted suicide. Thus it strikes us as bizarre that a judge in the Second Circuit could have suggested that the issue be remanded to the political process in New York, which had just completed an exhaustive treatment of the issue and had expressly rejected the conclusion urged by the lower court. No. 95-1858, Pet. App. 43a-44a (Calabresi, J., concurring). The en banc opinion in the Ninth Circuit cited this Task Force Report in a footnote, No. 96-110, Pet. App. A-74 note 84, but its opinion does not indicate that the en banc panel actually read the document they asked their readers to "see."

two governmental interests that bear more directly on the theme of personal liberty.

(1) Protecting the role of physicians as healers, not killers.

First, a state has a legitimate interest in not having physicians in the role of killers of their patients. One way of thinking of this interest is that the state may preserve the integrity of the physician's practice, which has for centuries explicitly prohibited doing any harm to patients.[8] More recently and more explicitly, § 2.211 of the American Medical Association's *Code of Medical Ethics* (1994) declares: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."

Another way of thinking of the legitimacy of this governmental interest is that it concerns public health or the well-being of the entire community. Thus, as Judge Noonan suggested, "Not only would the self-understanding of physicians be affected by removal of the state's support for their professional stance; the physician's constant search for ways to combat disease would be affected, if killing were as acceptable an option for the physician as curing. The physician's commitment to curing is the medical profession's commitment to medical progress." No. 96-110, Pet. App. D-15. When the well-being of all persons is diminished by a shift in constitutional standards, that shift cannot be defended as an enhancement of personal liberty.

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[8] For an extensive treatment of the significance of the Hippocratic Oath, *see* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* (1991); Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (1991); Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (1943); and *see* Brief Amicus Curiae of Christian Medical & Dental Society in No. 95-1858 and No. 96-110.

(2) Preventing the abuse of widespread involuntary euthanasia

Second, a state has a legitimate interest in preventing involuntary active euthanasia. This abuse is not hypothetical. It has occurred in two modern democracies in our own century, the Netherlands and Germany. When these two experiences are explored carefully, several closely related propositions emerge that have a dreadful resemblance to the brave new world we fear will emerge in a regime of physician-assisted suicide. First, high-sounding generalizations about the human good can mask terrible evil. Second, massive self-deception or willful blindness sets in and prevents close empirical inspection of the established program. Third, when the purposes and effects of the norms in society are themselves evil, otherwise good people – including physicians – can become complicit in massive evil simply by taking the easy path of conforming to the "normal." Fourth, the law has an educative function for good or for ill, and a medical program that has the force of law has a powerful ability to shape culture and to confer legitimacy upon atrocity.

Since 1984, legal guidelines in the Netherlands have tacitly allowed assisted suicide or euthanasia in response to a repeated, voluntary request from a suffering, competent, terminally ill patient, the same line drawn by the courts below. In 1991 the government established the Rimmelink Committee to determine the actual number of deaths by euthanasia and to gain insight into this practice. The Rimmelink Committee discovered that by 1990, approximately 2,700 cases of assisted suicide occur annually, amounting to two percent of all deaths.[9] Within less than a decade of this shift in

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[9] In this country, two percent of deaths would amount to more than 43,000 cases of physician-assisted suicides a year. If this Court intends to set up a regime of physician-assisted suicide confident that abuse can be prevented "while this Court sits," *Panhandle Oil Co. v. Mississippi ex rel. Knox*, 277 U.S. 218, 223 (1928) (Holmes, J., dissenting), its docket will be very full of these cases for years to come.

standards, the Rimmelink Committee concluded that none of the initial lines drawn by Dutch Law had held. In the cases reported to the Committee, Dutch physicians admitted that in 1,000 additional cases they had intentionally taken the patient's life involuntarily, without an explicit request from either patient or family. And there is a large number of unreported cases in this category of "life terminating acts without the explicit request of the patient." *See* New York State Task Force, *When Death Is Sought*, 133-134; Johannes J. M. van Delden, Loes Pijnenborg and Paul J. van der Maas, *The Remmelink Study: Two Years Later*, 23 Hastings Center Report 24 (Nov.-Dec.1993); Subcommittee on the Constitution, House Jud. Comm., *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Cong., 2d Sess. (1996). Whatever else may be said about the sudden and widespread practice of active involuntary euthanasia in the Netherlands, this dramatic shift away from patient involvement in such a momentous decision cannot plausibly be justified as an enhancement of personal liberty.

Recent studies also enable sharp focus on the Nazi program of physician-assisted eugenics and euthanasia that was central to its plan of creating an ethnically pure super-race. *See* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* 68-91 (1991); Ingo Muller, *Hitler's Justice: The Courts of the Third Reich* 120-26 (1991); Robert Proctor, *Racial Hygiene: Medicine under the Nazis* (1988); Benno Muller-Hill, *Murderous Science* (1988); Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* 46-79 (1986). Because of the massive evils perpetrated by the Nazis, *see, e.g.*, Lucy Davidowitz, *The War Against the Jews, 1993-1945* (1975), it is easier to see clearly the evil of the Third Reich than to recognize an analogous situation in the Netherlands or in our own society. As churches with deep historical roots in Germany, we have reflected soberly on the full horror of the Third Reich and on the tragic complacency of the church in the face of that horror. We have searched

fearlessly in this history for sobering lessons that apply to all cultures, including our own.

We acknowledge important differences between Nazi Germany and the current situation of involuntary euthanasia in the Netherlands or the regime we fear would occur in our own country if physician-assisted suicide is imbedded as a constitutional right. And we do not suggest any ideological connection between the Nazis and the respondents or their advocates. Nevertheless, we urge that some lessons might be gleaned from the past as we stand at the precipice of the creation of a new legal order in this country. At least in some respects, the role of some doctors in our future would be distressingly similar to the role some doctors were asked to play in the Third Reich, when large numbers of people in certain groups were judged "unworthy of life." See Lifton, *The Nazi Doctors, supra*, 21-144. That should be enough to give us pause before marching forward in this direction. At the very least, this Court should not lightly toss aside the decision of a state to stand firm by its commitment against physician-assisted suicide in the wake of the experience in the Netherlands.

II. Preserving the distinction between killing a person and allowing a person to die promotes the equal dignity of all persons; a regime of physician-assisted suicide would not.

As we noted above, the Second Circuit repudiated the Ninth Circuit's discovery of a liberty interest in physician-assisted suicide through the methodology of substantive due process. No. 95-1858, Pet. App. 16a-20a. But it held that "[t]he New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." No. 95-1858, Pet. App. 35a. We note again the language relied

upon by the Second Circuit to prevent abuse from physician-assisted suicide, and repeat that – especially in the wake of the recent experience in the Netherlands – these standards afford no protection against sliding down a very slippery slope towards widespread involuntary euthanasia. The narcissistic impulse, moreover, is so deeply entrenched in human life that we have no solid ground for trusting the court's naive faith in the inherent generosity of human compassion.

Although the equal protection methodology employed by the Second Circuit differs at least formally from the substantive due process methodology employed by the Ninth Circuit, the equal protection approach turns out to be just another way of imposing raw judicial power over the political process. Both courts attack the legitimacy of any governmental interest in prohibiting physician-assisted suicide. Since the Second Circuit conceded that there is no fundamental right to suicide, whether assisted or not, it should have deferred to the legislative judgment protecting human life. *See, e.g., Califano v. Aznavorian*, 439 U.S. 170 (1978); *New Orleans v. Dukes*, 427 U.S. 297 (1976); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955). Instead, it nullified the New York statute for essentially the same reasons as those offered by the Ninth Circuit. Only the constitutional shell is different. Hence the reasons we offered in Part I obtain with equal force here.

We comment now on the three other legitimate governmental interests identified by Judge Noonan because they bear directly on the theme of equality.

A. Protecting the elderly infirm from the grave risk of involuntary euthanasia.

A state has a legitimate interest in not subjecting the elderly infirm to psychological pressure to consent to their own deaths. The value of equality in our society may be described as a widening circle of inclusion. For example, at the dawn of the republic, African slaves and women were emphatically not regarded as equal in the eyes of the law. But radical constitutional changes imbedded in the Fifteenth and

Nineteenth Amendments have at least signalled that African-Americans and women are now constitutionally entitled to participate in our democracy by means of the franchise. More recently, momentous legislation has banned invidious discrimination on the basis of race in access to public accommodations, 42 U.S.C. § 2000a (Title II of Civil Rights Act of 1964), on the basis of race and gender in employment, 42 U.S.C. § 2000e (Title VII of Civil Rights Act of 1964), and on the basis of race in housing, 42 U.S.C. §§ 3601 et seq. (Title VIII of Civil Rights Act of 1968). More recently still, older persons have also been protected under the law. *See, e.g.*, 29 U.S.C. §§ 621 et seq. (prohibiting discrimination in employment on the basis of age within specified period of years).

We do not propose that all government policies that would have the effect of placing more significant burdens on older persons must be subject to the most exacting scrutiny previously reserved for racial classifications, or even to the intermediate scrutiny employed in cases involving gender-based classifications. But where, as here, a majority of the states has acted affirmatively to insure that older persons are surrounded with the protection of the laws, we do suggest that it is legitimate for this Court to find that the states have a rational basis for doing so. There is, in short, a plausible connection between a state's prohibition of physician-assisted suicide and its concern for older persons. For one thing, older persons are more vulnerable to the suggestion that, having lived a full life, they have now become a burden to society and even to their family. In these circumstances, it is not unreasonable to maintain that doctors should be the champions and best friends of older persons, not the state-approved harbingers and agents of their death. As Judge Noonan noted, "For all medical treatments, physicians decide which patients are the candidates. If assisted suicide was acceptable professional practice, physicians would make a judgment as to who was a good candidate for it. . . . 'Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation.' "

No. 96-110, Pet. App. D-15, D-16 (citing New York State Task Force, *When Death Is Sought*).

B. Protecting the poor and minorities from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons, especially those without access to health care, from exploitation. In our country over 40 million have no health care insurance at all, and managed health care has increasingly allocated health care services to maximize the economic interests of investors in health care organizations. Under these circumstances, we are deeply troubled that in a regime of physician-assisted suicide health care managers could easily rationalize a decision to induce the death of an unwanted and vulnerable person, whose value in such a system would be measured exclusively in economic terms.

As we noted above, the theme of equality is a widening circle of inclusion. At the beginning of the republic, only property-owners could vote. Again, momentous changes in our century now ensure that the poor may participate in the democracy by means of the franchise. U.S. Const., Amend. XXIV. 42 U.S.C. § 1973 (Voting Rights Act of 1965, as amended); and *Kramer v. Union Free School Dist. No. 15*, 395 U.S. 621 (1969) (eliminating qualification of property ownership for participating in school board elections).

We realize that this Court does not recognize poverty as a suspect classification for purposes of equal protection analysis. *See, e.g., San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1972). These cases are not the vehicle for advocating any change in this approach now. But where, as here, a majority of the states has acted affirmatively to insure that all persons – irrespective of their financial ability to pay for adequate health care[10] – are surrounded with the protection of

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[10] The burden of inadequate health care continues to fall most heavily on the poor and minorities. *See, e.g.*, Marian Gornich et al., *Effects of Race*

the laws, it is legitimate for this Court to find that the states have a rational basis for doing so. As Judge Noonan noted, "The poor and minorities would be especially open to manipulation in a regime of assisted suicide for two reasons: Pain is a significant factor in creating a desire for assisted suicide, and the poor and minorities are notoriously less provided for in the alleviation of pain. The desire to reduce the cost of public assistance by quickly terminating a prolonged illness cannot be ignored: 'the cost of treatment is viewed as relevant to decisions at the bedside.' Convergently, the reduction of untreated (although treatable) pain and economic logic would make the poorest the primest candidates for physician-assisted and physician-recommended suicide." No. 96-110, Pet. App. D-16 (citing New York State Task Force, *When Death Is Sought*).

C. Protecting older persons from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons who are disabled from societal indifference and antipathy. The widening circle of inclusion has recently expanded to embrace persons with disabilities within its perimeters. Until fairly recently such persons could not participate fully in economic life. The law rendered them invisible as a group. Again, momentous changes in the law now ensure that the disabled may gain access to buildings and thus to education and employment. *See, e.g.*, Vocational Rehabilitation Act of 1973, 29 U.S.C. § 794; Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6001; Americans with Disabilities Act, 42 U.S.C. §§ 12601 et seq.

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and Income on Mortality and Use of Services Among Medicare Beneficiaries, 335 N. Eng. J. Med. 791 (1996). Thus the state would have an additional reason to ensure that these groups are not singled out for swift elimination because of class or racial prejudices masked under the label of physician-assisted suicide.

We recognize that this Court does not recognize disability as a suspect classification for purposes of equal protection analysis. *See, e.g., City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985). Again, we do not urge a change in this approach now. We merely note that where, as here, a majority of the states has acted affirmatively to insure that persons with disabilities are surrounded with the protection of the laws, it is legitimate for this Court to find that the states have a rational basis for doing so.

As Judge Noonan noted, "The vulnerability of residents of nursing homes and long-term care facilities to physician-assisted suicide is foreshadowed in the discriminatory way that a seriously-disabled person's expression of a desire to die is interpreted. When the nondisabled say they want to die, they are labelled as suicidal; if they are disabled, it is treated as 'natural' or 'reasonable.' *See* Carol J. Gill, *Suicide Intervention for Persons with Disabilities: A Lesson in Inequality*, 8 Issues in Law & Med. 37, 38-39 (1993). In the climate of our achievement-oriented society, 'simply offering the option of 'self-deliverance' shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it.' Richard Doerflinger, *Assisted Suicide: Pro-choice or Anti-Life?*, 19 Hastings Center Report 16, 17 (1989). An insidious bias against the handicapped – again coupled with a cost-saving mentality – makes them especially in need of Washington's statutory protection." No. 96-110, Pet. App. D-16.

Individually and convergently, the five legitimate governmental objectives discussed here outweigh any alleged constitutional liberty of suicide or of assistance in suicide by the medical profession. Both methodologies employed by the lower courts fail on their own terms.

CONCLUSION

Both lower courts have proposed a new constitutional order that would in a single stroke undermine the healing function of doctors by allowing them to become ministers of

death. Yet each court has cast doubt on the rationale of the other. The Second Circuit expressly rejected the substantive due process claim to assisted suicide adopted by the Ninth Circuit. The original panel in the Ninth Circuit rejected the equal protection claim that formed the basis for the analysis espoused by the Second Circuit; the en banc panel did not reach this claim. Thus the judges who would impose this result on our nation have not produced a coherent rationale for the startling departure in criminal law and constitutional interpretation that they propose. Uncertainty abounds on both predicates for the decisions advanced below. This court should not create a new constitutional regime of physician-assisted suicide, which would neither advance human freedom nor promote the equal dignity of all persons. The wiser course of action for this Court to pursue would be to reaffirm the role of the several states in surrounding human life with protection. The lower courts should be reversed.

Respectfully submitted,

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APPENDIX A

The Evangelical Lutheran Church in America, 1992 Message on End-of-Life Decisions

With this message, the Church Council of the Evangelical Lutheran Church in America, upon the recommendation of the Division for Church in Society, addresses some timely aspects of end-of-life situations and encourages further deliberation on the topic throughout this church. This message does not deal with the full scope of these complex matters. It draws upon a relevant social statement, "Death and Dying," of a predecessor church body as basis for the guidance it offers.[1]

The Occasion

An elderly woman contemplates in terror the possibility that she might be kept alive for months by means of life-support systems. A son visits a nursing home weekly to see his 95 year-old mother, who is stricken with Parkinson's disease and who wants to die. Family and friends share the slow, anguishing death of a young man with AIDS. Parents agonize with their pastor over what to do about their daughter who survives in a persistent vegetative state after a car accident.

Increasingly, people know from their own experience similar painful dilemmas. While the achievements of modern medicine have been used to prolong and enhance life for many, they have also helped create an often dreaded context for dying. Costly technology may keep persons alive, but frequently these persons are cut off from meaningful relationships with others and exist with little or no hope for recovery. Many fearfully imagine a situation at the end of their lives where they or their trusted ones will have no say in decisions about their treatment.

In this context, new emphasis is being placed on the rights of patients. Recent federal legislation, for example, requires all health care facilities receiving Medicare or Medicaid monies

to inform patients of their right to make medical treatment decisions. This includes the right to specify "advance directives,"[2] which state what patients wish to be done in case they are no longer able to communicate adequately.

We consider the legislation consistent with the principle that "respect for that person [who is capable of participating] mandates that he or she be recognized as the prime decision-maker" in treatment.[3] The patient is a person in relationship, not an isolated individual. Her or his decisions should take others into account and be made in supportive consultation with family members, close friends, pastor, and health care professionals. Christians face end-of-life decisions in all their ambiguity, knowing we are responsible ultimately to God, whose grace comforts, forgives, and frees us in our dilemmas.

Which decisions about dying are morally acceptable to concerned Christians, and which ones go beyond morally acceptable limits? Which medical practices and public policies allow for more humane treatment for those who are dying, and which ones open the door to abuse and the violation of human dignity? Proposals in various states to legalize physician-assisted death[4] point to renewed interest in these old questions. ELCA members, congregations, and institutions need to address these questions through prayer and careful reflection.

A Christian Perspective

Our faith as Christians informs and guides us in approaching personal and public decisions about death and dying today. Among the convictions that orient us are:

- life is a gift from God, to be received with thanksgiving;
- the integrity of the life processes which God has created should be respected; both birth and death are part of these life processes;

- both living and dying should occur within a caring community;
- a Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions;
- truthfulness and faithfulness in our relations with others are essential to the texture of human life; and,
- hope and meaning in life are possible even in times of suffering and adversity a truth powerfully proclaimed in the resurrection faith of the church.[5]

"Whether we live or whether we die, we are the Lord's" (Romans 14:8). For those who live with this confidence, neither life nor death are absolute. We treasure God's gift of life; we also prepare ourselves for a time when we may let go of our lives, entrusting our future to the crucified and risen Christ who is "Lord of both the dead and the living" (Romans 14:9).

While these convictions do not give clear-cut answers to all end-of-life decisions, they do offer a basic approach to them.

Allowing Death and Taking Life

Withholding or Withdrawing Artificially-administered Nutrition and Hydration

Patients who once would have died because of their inability to take food and water by mouth can today be kept alive through artificially-administered nutrition and hydration. These measures are often temporary and allow many to recover health. At other times, however, they alone maintain life, and they may do so indefinitely. In those cases, is it ever morally permissible to withhold or withdraw such measures?

Food and water are part of basic human care. Artificially-administered nutrition and hydration move beyond basic care to become medical treatment. Health care professionals are not required to use all available medical treatment in all circumstances. Medical treatment may be limited in some instances, and death allowed to occur. Patients have a right to refuse unduly burdensome treatments which are disproportionate to the expected benefits.

When medical judgment determines that artificially-administered nutrition and hydration will not contribute to an improvement in the patient's underlying condition or prevent death from that condition, patients or their legal spokespersons may consider them unduly burdensome treatment. In these circumstances it may be morally responsible to withhold or withdraw them and allow death to occur. This decision does not mean that family and friends are abandoning their loved one.

When artificially-administered nutrition and hydration are withheld or withdrawn, family, friends, health care professionals, and pastor should continue to care for the person. They are to provide relief from suffering, physical comfort, and assurance of God's enduring love.

Refusal of Beneficial Treatment

Patients and health care professionals share a common concern that medical treatment be beneficial. In most situations, they have a common understanding of that benefit. When agreement exists, patients generally are willing to receive treatment. There are situations, however, when patients and health care professionals disagree on what will benefit the patient, or on whether the expected benefit is worth the risks and burdens involved. What is morally responsible in these situations?

Because competent patients are the prime decision-makers, they may refuse treatment recommended by health care professionals when they do not believe the benefits outweigh the risks and burdens. This is also the case for patients who are incompetent, but who have identified their wishes through advance directives, living wills, and/or conversation with family or designated surrogates.

Health care professionals are obligated to inform patients of medical treatment options and what in their best judgment are the potential benefits and burdens of such options. They are also obligated to obtain the consent of patients to provide treatment. Where this consent is not given, they should accept the desired limits of treatment, even when they do not agree with the decision.

A patient's refusal of beneficial treatment does not free health care professionals from the obligation to give basic human care and comfort throughout the dying process which may follow. Family, friends, and pastor need to accompany the person and share the promise of God's faithfulness in life and death.

Physician-Assisted Death

An emphasis on patients' rights, a health care system often unable to respond adequately to catastrophic illness, and the emergence of disease processes (such as AIDS and Alzheimer's disease) that threaten dramatic loss of human capacities are a few of the realities that have converged to create an environment where some patients ask that their life be ended. Is it ever morally permissible for a physician deliberately to act or authorize an action to terminate the life of a patient?

The integrity of the physician-patient relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals

also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death.

However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. As a church we affirm that deliberately destroying life created in the image of God is contrary to our Christian conscience.[6] While this affirmation is clear, we also recognize that responsible health care professionals struggle to choose the lesser evil in ambiguous borderline situations – for example, when pain becomes so unmanageable that life is indistinguishable from torture.

We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased.

Caring treatment that allows death to occur within the bounds of what is morally acceptable may help reduce the appeal of physician-assisted death. Hospice care offers promise of more humane treatment at the end of life. A more equitable health care system that more effectively responds to catastrophic illness and provides the needed follow-up care should also be a priority for those concerned about end-of-life decisions.

Ministry in Preparation for the End of Life

Advance directives are welcome means to foster responsible decisions at the end of life. Yet people are often overwhelmed and frightened when thinking about medical treatment and legal possibilities, and therefore do not take steps to prepare for the end of their lives. People recognize their rights as patients but at the same time feel unprepared to take on the responsibility.

Communities of faith should, can, and often do provide holistic ministry to prepare people for end-of-life decisions. Pastors can help people to deal with their fears and hopes. Congregations can offer opportunities for conversation and deliberation about the end of life. They can invite hospital chaplains, hospice care-givers, social workers, attorneys, or others knowledgeable about advance directives to help them consider the topic's many dimensions.

Church related hospitals, nursing homes, and other social ministry organizations are also encouraged to provide for continuing conversation and deliberation about their ministry at the end of life. The staff of these organizations need to understand the ethical principles that are to guide the care they provide. Ethics committees can play an important role in dealing with unresolved conflicts about treatment decisions.

We rejoice in the faithful and compassionate congregations, pastors, health care professionals, and church institutions who minister with persons who are dying and their families and friends. We give thanks for family and friends who minister to their loved ones. In the midst of often agonizing end-of-life decisions, we are reminded of the God-given mystery of both life and death. May the Holy Spirit grant to us all loving wisdom and confident hope in the Gospel's promise of eternal life.

Endnotes

[1] The social statement, "Death and Dying," was adopted in 1982 by the Lutheran Church in America. In 1977 The American Lutheran Church developed an analysis paper, "Death and Dying," which was not an actual social statement, but also provides background for this message. Both are available from the ELCA Distribution Service.

[2] "Advance directives" commonly include designation of a durable power of attorney, living wills, and an advance directive form. The exact meaning, however, may vary from state to state.

[3] LCA, "Death and Dying," p. 3.

[4] Physician-assisted death or "aid in dying" refers to situations in which a physician (or other health professional at the physician's request), in response to a patient's request, either administers a medication or performs a treatment, or enables the patient to do so, with the intent of bringing about that patient's death.

[5] The above convictions are quoted from LCA, "Death and Dying," pp. 2-3.

[6] LCA, "Death and Dying," p. 6.

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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1996

Dennis C. Vacco, et al.,
Petitioners

v.

Timothy E. Quill, M.D., et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

State of Washington,
Petitioner

v.

Harold Glucksberg, et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE PROJECT ON DEATH IN AMERICA, OPEN SOCIETY INSTITUTE, AS AMICUS CURIAE, FOR REVERSAL OF THE JUDGMENTS BELOW

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QUESTION DISCUSSED BY AMICUS

Whether the invalidation by the courts below of state laws prohibiting physician-assisted suicide should be overruled on the ground that the issue is not yet ripe for constitutional adjudication.[1]

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[1] Each party has given its consent, in writing, to the filing of this brief amicus curiae. Letters indicating such consent have been filed with the Clerk of the Court.

INTEREST OF AMICUS CURIAE

The Project on Death in America was established in 1994 by the Open Society Institute, a private non-profit operating foundation. Its mission is to understand and transform the culture and experience of dying in the United States through initiatives in research, scholarship, the humanities and the arts, and to foster innovations in the provision of care, public education, professional education, and public policy. This mission arose from a recognition, first, that the experience of dying has changed over the past several decades, with many more people enduring prolonged dying as a consequence of chronic and progressive disease and, second, that needless suffering -- physical, emotional, existential and spiritual -- too often accompanies these deaths, for both dying persons and survivors.

The Project takes no position on the question whether legal institutions should ultimately recognize a right to physician-assisted suicide, whether by legislative action or by judicial constitutional interpretation. Among individuals who are supported by, affiliated with, or responsible for the direction of the Project, there is no uniform view about whether physician-assisted suicide should be endorsed by legislative action or constitutional adjudication.

Among the enterprises supported by the Project, many are dedicated to implementing palliative care programs in hospital and community settings to alleviate the needless suffering that currently afflicts dying people and their families. Other supported programs are engaged in designing ways to enhance the autonomous choice of dying people in such matters as what treatments are provided to them, whether they die in institutional or home settings, and whether adequate financial and other community resources are available to support the choices preferred by dying people and their families. By these means, as well as by supporting evaluative research and

programs for public and professional education, the Project is addressing many of the justifiable fears that are the current predicates for the support of physician-assisted suicide, and is working to establish an adequate practical basis for evaluating effective safeguards for any future implementation of the practice of physician-assisted suicide.

Our goal is to promote a fully informed and equitable societal resolution of the question whether physician-assisted suicide should be legitimated, if at all, by legislation or as a constitutional right.

SUMMARY OF ARGUMENT

Legally recognized physician-assisted suicide is not currently in practice in any jurisdiction in the United States. It has not yet been implemented even in the one state (Oregon) where physician-assisted suicide was legalized by a popular referendum just two years ago. If this Court were to affirm the judgments below declaring a constitutional right to physician-assisted suicide, an abrupt, radical and utterly unprepared transformation of medical practice would be imposed on the entire country.

In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), which considered a constitutional claim to refuse life-prolonging medical treatment for a mentally incompetent person, this Court proceeded with considerable caution and refused to enunciate a uniform constitutional rule, deferring instead to the "divers[e] . . . number of sources" available to states in considering such a "perplexing question with unusually strong moral and ethical overtones." *Id.* at 277. This Court thus followed Justice Brandeis' classic injunction to avoid premature constitutional decisions that close off state "experimentation" regarding "changing social . . . needs." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 310 (1932) (dissenting opinion).

Following this judicious course does not necessarily foreclose some future constitutional determination regarding an individual right to physician-assisted suicide by this Court. In many other contexts -- such as constitutional interpretations of due process rights in criminal trials, and rights against cruel and unusual punishment -- this Court has purposefully and explicitly stayed its hand so that states might explore different solutions to novel, complex social problems. In these contexts, the Court has made clear that extensive prior deliberation and experimentation in Brandeis' "laboratory" of the states is a necessary prerequisite for an adequately informed, ultimate judicial decision to enunciate a uniform, binding constitutional resolution.

This necessary prerequisite of extensive state deliberation and experimentation has hardly even begun regarding legally recognized physician-assisted suicide. In particular, there are serious unanswered questions about the capacity of physicians or state officials to ensure that a gravely ill individual's choice for physician assistance in suicide is adequately voluntary, or that the individual is mentally competent or is appropriately diagnosed as terminally ill. In the instant cases, however, the Courts of Appeals held that any constitutional right to physician-assisted suicide must be limited to voluntary, mentally competent, terminally ill individuals. The courts below ignored the multiple uncertainties currently involved in applying these criteria in individual cases. Because it is not yet certain that adequate criteria can be developed or applied, it is premature for any court to determine whether there is a federal constitutional right to physician-assisted suicide. The question is not ripe for constitutional adjudication and will not become ripe for an indeterminate time while various states, free from judicially-imposed constitutional compulsion, consider whether or on what terms physician-assisted suicide should be authorized. The judgments below should accordingly be reversed.

ARGUMENT

I. COURTS SHOULD NOT PRE-EMPT PUBLIC DEBATE AND LEGISLATIVE ACTION BY PREMATURE CONSTITUTIONAL RESOLUTION OF ISSUES WITH SUCH COMPLEX DIMENSIONS AS PHYSICIAN-ASSISTED SUICIDE.

A. Justice Brandeis' Approach: For "Novel Social Experiments," Courts Should Withhold Constitutional Resolution While Individual States, Serving As "Laboratories," Develop Adequate Practical and Research Experience.

The instant case is strikingly similar to *New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932). In the heyday of its invocations of substantive due process to overturn state social and economic regulations, the Court held that a state law requiring a license to manufacture, sell or distribute ice was unconstitutional on the ground that this activity was "essentially private in nature" and that "under [the fourteenth] amendment, nothing is more clearly settled than that it is beyond the power of a state, 'under the guise of protecting the public, arbitrarily [to] interfere with private business . . . '." *Id.* at 277-78. Justice Brandeis dissented from this sweeping application of the "privacy" norm, in an opinion which the modern Court has acknowledged as "classic." *Whalen v. Roe*, 429 U.S. 589, 597 n. 20 (1977).

Justice Brandeis' reasoning applies with equal force to the invocations of constitutional norms of "privacy" or "arbitrariness" to overturn state laws against physician-assisted suicide, as in the Ninth and Second Circuit rulings in the instant case. Justice Brandeis' dissent makes this application clear:

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious, or unreasonable. . . . But, in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold.

285 U.S. at 311.

In *New State Ice Co.* the Court prevented experimentation on a complex question of social and economic policy by striking down the novel state law. But that is not the only way that constitutional adjudication can override what Justice Brandeis referred to as the "value of the process of trial and error" in social experimentation. *Id.* at 310. A court can also prevent experimentation by prematurely imposing a constitutional resolution for the entire country regarding a novel and difficult issue at a time when individual states are engaged in testing the unknown or inadequately understood dimensions of this issue.

Assessing the merits and demerits of physician-assisted suicide is, in Justice Brandeis' words, "a formidable task" involving a "multitude of judgments." *Id.* (For a specification of many of the empirical uncertainties regarding this practice, *see* Part II, *infra).* Thus far only one state has directly embarked on this task by resolving to effectuate the practice; implementation of this experiment by the state of Oregon has been blocked by a federal district court's constitutional ruling.

Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (this ruling was explicitly disapproved in the Ninth Circuit opinion under review here, 79 F.3d at 839 & nn. 138-39). But this impediment should be removed and we would then have the benefit of what Justice Brandeis called "one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co.*, 285 U.S. at 311.

B. Regarding Physician-Patient Relations, the Modern Court Has Applied Justice Brandeis' Approach to Avoid Premature Constitutional Resolution of Novel, Factually Complex Issues.

The decision of this Court most directly relevant to the instant case is *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). *Cruzan* was "the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a 'right to die.' " *Id.* at 277. In *Cruzan*, the Court effectively endorsed Justice Brandeis' admonition to withhold constitutional resolution in order to promote the development of diverse state approaches. The Court favorably acknowledged the "diversity" of state common-law approaches to the "perplexing question with unusually strong moral and ethical overtones" of withholding life-prolonging medical treatment from incompetent patients. *Id.* The Court observed that a constitutional resolution of this question would wrongfully truncate the range of relevant considerations because of the "simpl[e] and stark" way that the issue would be posed in constitutional adjudication, whereas individual states have a "number of sources" available to them "which are not available to us" in federal constitutional adjudication. *Id.*

Cruzan explicitly acknowledged that the state regulation in that case directly impinged on the exercise of a

constitutionally protected "liberty interest." *Id.* at 278. The Court nevertheless recognized the propriety of diverse state approaches to the issue in light of its complex factual context.[2]

Justice O'Connor made clear in her concurring opinion in *Cruzan* that the Court's deference to diverse state approaches did not mean that no authoritative constitutional resolution would ever be judicially imposed,[3] but only that such a resolution would be premature in light of the novelty and factual complexity of the issue.[4]

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[2] The Court observed, "We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196 (1897), where we said that in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.' " 497 U.S. at 277.

[3] Justice O'Connor stated:

> Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. As is evident from the Court's survey of state court decisions . . . no national consensus has yet emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, *New State Ice Co. v. Liebmann* . . . (Brandeis, J., dissenting), in the first instance. (497 U.S. at 292).

[4] In another case that also directly impinged on constitutional rights in physician-patient relations, this Court was equally unwilling to impose a "simpl[e] and stark" constitutional rule. In *Whalen v. Roe*, 429 U.S. 589 (1977), the state had required physicians to report the names and addresses of patients for whom they prescribed certain medications and a lower court ruled that this requirement invaded "one of the zones of privacy accorded

(Continued)

C. The Modern Court Has Applied Justice Brandeis' Approach to Promote State Experimentation and Avoid Premature Constitutional Resolution in Many Other Contexts.

In a series of decisions addressing different constitutional provisions, the Court has purposefully withheld constitutional resolution in order both to permit and to promote experimentation by states. The underlying premise of these decisions has been that the experience and knowledge gained in these diverse state efforts would serve to clarify and refine the constitutional issues before any final judgment by this Court.

1. Interpreting the Fourteenth Amendment due process right to a fair trial.

Chandler v. Florida, 449 U.S. 560 (1981), was a constitutional challenge to the state's newly-instituted practice of broadcasting the proceedings of a criminal trial notwithstanding a defendant's objection. The Court ruled that on the facts of the specific case before it, no constitutional violation had been demonstrated. *Id.* at 574. The Court refused, however, to enunciate a general constitutional rule binding for future cases. "It is clear that the general issue of the psychological impact of broadcast coverage upon the participants in a trial, and particularly upon the defendant, is still a subject of sharp debate. . . . Comprehensive empirical data are still not available -- at least on some aspects of the problem." *Id.* at 577. The Court acknowledged that the state's

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constitutional protection" in the doctor-patient relationship. The Supreme Court acknowledged that the state regulation had "some effect on individual liberty or privacy" but nonetheless concluded that "individual States [must] have broad latitude in experimenting with possible solutions to problems of vital local concern." *Id.* at 597.

action might "have an adverse effect" on the "detached atmosphere" necessary to protect a defendant's right to a fair trial. *Id.* at 578. Nonetheless, the Court found that "at present no one has been able to present empirical data sufficient to establish" this proposition, that "further developments and more data are required before this [constitutional] issue can be finally resolved." *Id.* at 578-80 & n. 12.

Notwithstanding the possibility that the continuation of the state policy would infringe on the fair trial right, the Court in *Chandler* clearly ruled that it was premature to resolve the constitutional issues until more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. The Court observed, "[T]he very broadcast of some trials potentially [may be] a form of punishment in itself -- a punishment before guilt. This concern is far from trivial. But, whether coverage of a few trials will, in practice, be the equivalent of . . . the public pillory long abandoned as a barbaric perversion of decent justice . . . must also await the continuing experimentation." *Id.* at 580-81. Citing "the admonition of Justice Brandeis, dissenting in *New State Ice Co.*," the Court concluded, "This concept of federalism . . . favoring Florida's experiment, must guide our decision." *Id.* at 580.

2. Interpreting the Eighth Amendment right against cruel and unusual punishments.

In several instances the Court has held that it would be premature to impose a uniform constitutional rule in the administration of capital punishment until more state legislatures had acted, more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. In *Penry v. Lynaugh*, 492 U.S. 302 (1989), the Court considered a constitutional claim that execution of mentally retarded people violated the Eighth Amendment ban against "cruel and unusual punishment." The

Court refused to endorse this constitutional claim but, at the same time, explicitly refused to rule out the possibility that future actions by state legislatures might someday justify the Court's proclamation of such a right.[5]

In a case decided just one year earlier, Justice O'Connor was equally explicit that constitutional judgment should be withheld until state legislatures had independently deliberated on the matter. In *Thompson v. Oklahoma*, 487 U.S. 815 (1988), the Court divided four-to-four on the question whether the Constitution forbade execution of a person under 16 years of age. In her separate opinion which constituted the rule of the case, Justice O'Connor refused to resolve the constitutional question and instead held only that no such juvenile could be executed without explicit statutory prescription by the state legislature. *Id.* at 855. Justice O'Connor concluded that more "careful consideration" on this issue should take place among state legislatures. *Id.*[6]

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5 The Court stated:

> Only one state [Georgia] . . . currently bans execution of retarded persons. . . . Maryland has enacted a similar statute which will take effect [imminently]. . . . [The petitioner] points to several public opinion surveys that indicate strong public opposition to execution of the retarded. . . . The public sentiment expressed in these and other polls and resolutions may ultimately find expression in legislation, which is an objective indicator of contemporary values upon which we can rely. But at present, there is insufficient evidence of a national consensus . . . for us to conclude that it is categorically prohibited by the Eighth Amendment. (492 U.S. at 334-35).

6 Justice O'Connor wrote:

> The day may come when we must decide whether a legislature may deliberately and unequivocally resolve upon a policy authorizing capital punishment for crimes committed at the age of 15. . . . In my view, however, we need not and should not decide the question today. . . .

(Continued)

The Eighth Amendment may appear especially hospitable to such deference to evolving legislative attitudes and experience since it forbids not simply "cruel" but also "unusual" punishments, and the Court has held that legislative actions might themselves be a measure of "unusualness."[7] Nonetheless there is a more fundamental parallel between the jurisprudence of the Eighth and Fourteenth Amendments which establishes the equal relevance of state legislative actions for judicial interpretations of other constitutional provisions.

3. Interpreting Fourteenth Amendment "privacy" or "liberty" interests.

In *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958), the Court stated "that the words of the [Eighth] Amendment are not precise, and that their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." This evolutionary conception is precisely the interpretive guide that Justice Harlan identified in his now-classic concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479, 499 (1965), incorporating by reference his dissenting opinion in *Poe v.*

> By leaving open for now the broader Eighth Amendment question . . . , the approach I take allows the ultimate moral issue at stake in the constitutional question to be addressed in the first instances by those best suited to do so, the people's elected representatives. (*Id.* at 855, 858-59).

7 Amicus Curiae believes that in the specific substantive contexts of these cases, the Court erred in refusing to prohibit on constitutional grounds the execution of mentally retarded persons or of minors under sixteen. Amicus relies on these cases only for the jurisprudential proposition that the Court may decline to declare a constitutional right while explicitly holding open the possibility of a future judicial declaration based on further state legislative developments.

Ullman, 367 U.S. 497, 522 (1961) ("Due process has not been reduced to any formula . . . . [I]t has represented the balance which our Nation, built upon postulates of respect for the individual, has struck between that liberty and the demands of organized society . . . having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing." 367 U.S. at 542).

In interpreting the Fourteenth Amendment due process guarantee in *Griswold*, it is clear that Justice Harlan gave the same weight to the accumulated actions and experience of state legislatures generally as the Court gave in its interpretations of the Eighth Amendment in *Penry* and *Thompson*. Justice Harlan stated, "[C]onclusive, in my view, is the utter novelty of this enactment. Although the Federal Government and many States have at one time or other had on their books statutes forbidding or regulating the distribution of contraceptives, none . . . has made the use of contraceptives a crime." *Poe v. Ullman*, 367 U.S. at 554 (emphasis in original).

In evaluating the Fourteenth Amendment due process claim advanced in the instant case, the absence of any state legislative endorsement except for the "utter novelty" of the Oregon statute leads to the conclusion that a constitutional right to physician-assisted suicide is not yet supported by a sufficient "national consensus" (*Penry*) or by "evolving standards of decency" (*Trop*) or by "the balance which our Nation . . . has struck between . . . liberty and the demands of organized society" (*Griswold*). The Courts of Appeals' decisions in this case turn Justice Harlan's reasoning upside down: instead of relying on the collective judgments of forty-nine states to support the imposition of a constitutional rule on one, these decisions effectively impose one lone state's judgment on the other forty-nine.

It is also relevant that when this Court invalidated state laws restricting abortion in *Roe v. Wade*, 410 U.S. 113 (1973), abortions were legally available in every state in some circumstances: to save the mother's life in all states, to safeguard the mother's physical or mental health in "about one third of the states" and simply on demand in four states. *See id.* at 139-40 & n. 37. (Indeed, the statutory criteria regarding the mother's physical or mental health were so liberally construed in some states as to virtually amount to a regime of abortion on demand. *See* Kristin Luker, ABORTION AND THE POLITICS OF MOTHERHOOD, 88-95 (1984).) State legislative endorsement of abortion was thus not an "utter novelty" as it currently is for physician-assisted suicide.

II. CONSTITUTIONAL RESOLUTION IS PREMATURE BECAUSE SUBSTANTIAL UNCERTAINTIES EXIST REGARDING THE POSSIBILITY OF DESIGNING EFFECTIVE SAFEGUARDS FOR THE PRACTICE OF PHYSICIAN-ASSISTED SUICIDE.

Both the Second and Ninth Circuit Courts of Appeals insisted that the constitutional right to physician-assisted suicide must only apply to individuals who voluntarily request it, who are mentally competent and who are terminally ill. *See Compassion in Dying v. Washington*, 79 F.3d at 793; *Quill v. Vacco*, 80 F.3d 716, 718 (2d Cir.), *cert. granted*, 135 L. Ed. 2d. 1127 (1996). Both courts acknowledged that states have a legitimate interest in prescribing safeguards to ensure that the practice is strictly limited to volunteering, mentally competent, terminally ill people. *See* 79 F.3d at 832-33; 80 F.3d at 730-31 & n. 4. Both courts assumed that sufficient empirical knowledge and professional experience were currently available on which states might rely in designing such safeguards. 79 F.3d at 826, 831, 833; 80 F.3d at 730-31.

These assumptions about the current preparedness of the states and the medical profession to design effective safeguards are false. For patients who might request physician-assisted suicide, there are considerable practical problems in assuring voluntariness, in both diagnosing and appropriately treating mental incompetence, and in determining terminal prognoses. These problems might be overcome in the future if empirical research is conducted and, in particular, if the new Oregon statute comes into effect and is carefully monitored, and if currently untested changes in medical education and institutional practices are implemented to prepare physicians for this novel, legally-recognized role. But there is no sufficient current basis in practical experience or rigorous empirical research for any confidence that adequate safeguards can be developed. The courts below have no basis for their assumptions that physician-assisted suicide can in practice be appropriately restricted to voluntary, mentally competent, terminally ill people. It is thus clearly premature for the judiciary to declare the existence of a constitutional right to physician-assisted suicide on the premise that this right must extend only to voluntary, mentally competent, terminally ill people.[8]

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[8] Similar difficulties may exist in assuring the voluntariness and mental competence of gravely ill individuals who refuse life-prolonging treatment. But the possible existence of such similarities provides no reason for extending a constitutional right from this narrower context of an individual's liberty interest in resisting unconsented bodily intrusions; the possible similarities provide strong reasons for caution rather than expansive adjudication. This Court, moreover, was appropriately cautious in its consideration of constitutional claims to refuse treatment in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), acting only after this right had been recognized during the preceding fifteen years by some fourteen state appellate court decisions. *Id.* at 277 n. 6. By contrast, only one state supreme court has just recently addressed the question of physician-assisted suicide presented in this case, *People v. Kevorkian*, 447

(Continued)

A. Voluntariness

1. A dying person suffering from intense pain cannot voluntarily choose suicide unless available, effective pain treatment is offered.

The most powerful and poignant argument on behalf of legalizing physician-assisted suicide is to provide release for terminally ill people from intense, intractable pain. For anyone forced to choose between continued life with such pain and the release of death, the pain obviously exerts an enormous and even overwhelming coercive impact. This impact in itself obviously cannot justify characterizing a choice for death as "involuntary." If, however, this pain is actually avoidable but the suffering individual is neither informed of this fact nor given the opportunity to alleviate this terrible pain, then this individual is not acting voluntarily in choosing death as the only or even the preferred way to end suffering.

Many dying people in this country today are suffering from insufficiently treated pain.[9] Medically effective

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Mich. 436, 527 N.W.2d 714 (1994), *cert. denied sub nom., Hobbins v. Kelley*, 115 S.Ct. 1795 (1995), and refused to find a constitutional right in the context of Jack Kevorkian's ministrations in that state.

[9] How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al. reported that three of every four cancer patients had pain. Bonica's review of published reports indicates that more than half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996) (citations omitted) (*hereinafter, Good Care of the Dying Patient*). *See also* C.S. Cleeland, et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 N. Eng. J. Med. 592 (1994).

techniques for completely alleviating this pain are available for almost all of these people; according to knowledgeable physicians and researchers, this is possible in as many as ninety-eight percent of cancer cases.[10] But the medical profession generally is neither informing patients of this possibility nor providing this palliative care.[11]

We do not adequately understand the reasons for this failure by the medical profession; nor do we understand how this medical failure can be effectively remedied. There are many possible explanations, such as: insufficient knowledge among physicians about pain management because of inadequate professional training; state and federal legal restrictions on availability of controlled substances for pain

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[10] [O]nly 2% of patients in hospice care experience pain that is difficult for a skilled team to manage. With the exception of one study, other investigators confirm this low rate of serious pain persisting in systems of care that emphasize pain management. The rates of pain in persons who are dying of diseases other than cancer are not [however] well described.

Good Care of the Dying Patient, 275 JAMA at 475 (citations omitted).

[11] The potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts. . . . Although guidelines and a curriculum on pain management have been developed, oncologists and others report serious perceived shortcomings in management of cancer pain.

Good Care of the Dying Patient, 275 JAMA at 475. Other distressing symptoms of dying patients, in addition to pain, are also inadequately treated by physicians. *See* Susan Block & Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Arch. Intern. Med. 2039, 2040 (1994) ("Other symptoms [beyond pain] (eg., dyspnea, anorexia, nausea, constipation, insomnia, and anxiety) regularly plague terminally ill patients and are often inadequately controlled by physicians who lack expertise in palliative care or fail to take an aggressive stance toward assuring patient comfort.").

relief and/or physician misconceptions about the legal restrictions; failure even to acknowledge a patient's pain because of unwillingness or inability of physicians and other medical personnel to engage in more than perfunctory conversation, or in many cases any conversation, with patients who are perceived as dying.[12]

The explanation for this failure cannot plausibly be cruelty or callousness of the medical profession; there is widespread acknowledgment and dismay within the profession about our failure to provide even minimally adequate pain palliation for most dying people. But we do not know enough about the causes of this failure to prescribe confidently effective remedies for it.

The most recent and disturbing indication of our ignorance is the research results of the so-called SUPPORT project. This four year study involving nine thousand seriously ill adult patients in five U.S. teaching hospitals was designed "to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying." Alfred P. Connors, et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients; The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments* (SUPPORT), 274 JAMA 1591 (1995). Phase I of the study, to establish the empirical base-line of practices current in 1989-91, documented that overall "50% of all conscious . . . patients who died in the hospital experienced moderate or severe pain at least half the time

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[12] *See* Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-93 (1991); M.B. Max, *Improving Outcomes of Analgesic Treatment: Is Education Enough?* 113 Ann. Int. Med. 885 (1990); J.H. Von Rouenn, et al., *Physician Attitudes and Practice in Cancer Pain Management*, 119 Ann. Int. Med. 121 (1993).

during their last 3 days of life" although there was "substantial variation" among the five hospitals. *Id.* at 1594.[13] In Phase II, conducted in 1992-94, patients were divided into intervention and control groups, with the intervention group receiving intensive services from a "specially trained nurse" who, among other functions, facilitated communication and "encouraged attention to pain control" between the medical care team and patients and their families. 274 JAMA at 1591. Unfortunately, this "phase II intervention failed to improve care or patient outcomes." *Id.* In particular, reports of untreated pain during the last three days of life actually somewhat increased among intervention group patients as compared to control group patients. *Id.* at 1595.

The SUPPORT study was the most comprehensive research on the experience of dying patients ever conducted in this country. The failure of its intervention not simply to correct but even to measurably affect the problem of unnecessary but untreated pain among dying patients is a puzzling result.[14] Amicus curiae, the Project on Death in

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[13] This base-line result was consistent with numerous other prior research reports. *See Cancer Pain Relief and Palliative Care*, 19, World Health Organization (Report of a WHO Expert Committee) (1990).

[14] As the researchers observed:

> The study certainly casts a pall over any claim that, if the health care system is given additional resources for collaborative decision making in the form of skilled professional time, improvements will occur. . . . [T]he overall results of this study are not encouraging. No pattern emerged that implied that the intervention was successful for some set of patients or physicians or that its impact increased over time. The five hospitals had been chosen for their diversity and their willingness to undertake a substantial and controversial challenge. Yet none showed a tendency toward improvement in these outcomes.

274 JAMA at 1596. *See generally Dying Well in the Hospital: The Lessons of SUPPORT*, 25 Hastings Center Report, Special Supp. S1-S36 (1995).

America of the Open Society Institute, is currently supporting the establishment of palliative treatment programs as well as research into the effectiveness of such programs in medical centers throughout the country. We hope that this work will soon demonstrate a considerable improvement of the current, intolerable regime of dying patients suffering unnecessary, treatable pain.

So long, however, as substantial numbers of dying people are unnecessarily suffering from treatable pain, no one can claim that an individual's choice to end his life rather than endure pain is a sufficiently voluntary act. States cannot design adequate safeguards to assure that every suffering person has access to available pain control treatment when we do not yet understand the reasons why such treatment is not being provided to large numbers of patients. Until state authorities, assisted by medical researchers, have understood these reasons and identified effective remedies, judicial pronouncement of a right to physician-assisted suicide, premised on the voluntary character of an individual's choice, would clearly be premature.

It is also possible that, in itself, recognition of a right to physician-assisted suicide would create barriers to the provision of effective pain control and other symptomatic relief to dying patients. This paradoxical result could arise because some pharmacologic measures that are medically necessary to relieve intense pain or other symptoms can also have the unintended effect of hastening death. Even though such measures violate neither legal nor ethical proscriptions, some physicians are currently reluctant to administer adequate palliative medications because of their potential life-shortening effect.[15] If physician-assisted suicide were legalized and

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[15] *See Cancer Pain Relief and Palliative Care*, 52-53, World Health Organization (Report of a WHO Expert Committee) (1990).

accompanied by stringent procedural safeguards, many more physicians might conclude that even their current practices of pain control might require observance of these stringent new procedures. The net result could be the imposition of new barriers to the provision of currently recognized palliative care measures, thus increasing the already large numbers of patients who suffer needlessly from inadequate pain control. This paradoxical result would not inevitably follow from legalized physician-assisted suicide, but carefully designed implementation measures would be required to guard against this possibility. In common, however, with all of the current barriers to inadequate medical provision of palliative measures, we do not yet know enough about the underlying reasons for these barriers in order to design effective remedies to overcome them.

2. Undue financial pressures can undermine the voluntariness of a dying person's choice for suicide.

Prolonged dying from chronic illness, which is the increasingly common mode of death in this country, can be extremely expensive for patients and their families, as well as for private and public health insurers.[16]

Institutional arrangements in the delivery of health care are now in the midst of a fundamental transformation, as increasingly large numbers of patients are choosing, or are being forced by their employers or by state agencies to accept, the provision of medical treatment through managed care organizations. "The most troubling issue for end-of-life care in managed care is the possibility that clinicians are changed from being patients' advocates to having a personal stake in

[16] *See generally* K.E. Covinsky et al., *The Impact of Serious Illness on Patients' Families*, 272 JAMA 1839 (1994).

withholding treatment that would be in the patients' interests." Steven Miles, et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 Western J. Med. 302, 304 (1995).[17]

Because the dominance of managed care organizations in American health care is relatively recent, there has been little systematic study of the extent of inappropriate cost-cutting pressures on patients. But if physician-assisted suicide suddenly becomes a constitutionally-sanctioned option for all patients, it is certainly plausible and perhaps even likely that budget-minded health care organization managers and their physician-employees would press their dying patients toward exercising this option.

Perhaps traditional patient-centered medical ethics would guard against this improper pressure; perhaps external regulation of the new health care organizations would adequately protect dying patients against undue influence. But our experience of managed care is too new for any confident claims on this score. And yet, as Judge Reinhardt's opinion for the Ninth Circuit explicitly recognized, without carefully designed safeguards to counteract "the risk of undue influence" for financial gain, a dying person's choice of physician-assisted suicide would not be a truly voluntary act. 79 F.3d at 826.

[17] As Miles, et al. observe:

> Health maintenance organizations (HMOs), preferred provider plans, and managed indemnity insurance cover 80% of the privately insured persons in the United States. Recent large-scale extensions of managed care to public programs of Medicare and Medicaid ensure the continued rapid growth of managed care. The raison d'etre of managed care is to contain the growth of the cost of end-of-life care. About 10% of health care resources are used for the care of persons in their last year of life. (163 Western J. Med. at 302).

Unjustified financial pressures would be even more powerful for the large proportion of the American public without any health insurance, some thirty-seven million according to recent estimates.[18] Once again Judge Reinhardt's opinion noted the problem ("We would be inclined to agree that the country's refusal to provide universal health care, and the concomitant suffering so many Americans are forced to undergo, demonstrates a serious flaw in our national values," 79 F.3d at 826), but nonetheless failed to acknowledge the central relevance of this problem to the constitutional legitimization of physician-assisted suicide. Unless there can be adequate assurances that no person chooses physician-assisted suicide because of poverty, this choice cannot be considered sufficiently voluntary. The judiciary is, however, neither institutionally capable nor constitutionally authorized to create a system to guarantee health care regardless of income.[19] If there should be a right to physician-assisted suicide, it must be accompanied by general recognition of society's obligation to ensure access to adequate health care. The judiciary acting alone cannot achieve this goal.

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[18] *See* Michael Wines & Robert Pear, *Health Costs Pose Problems for Millions, A Study Finds*, N.Y. Times, Oct. 23, 1996, at A18, col. 1.

[19] *See, e.g., San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1 (1973) (complex issues regarding equalization of school financing are not amenable to judicial resolution based on a constitutional claim for equal protection); *Dandridge v. Williams*, 397 U.S. 471 (1970) (state welfare law computations of family financial need are not amenable to judicial resolution based on equal protection claims).

B. Mental Competence

1. Judgment-impairing confusion is common among dying persons but is surprisingly difficult to identify as such.

"Confusional states are common" among dying people and, accordingly, "obtaining a truly informed consent is problematic."[20] It might seem self-evident that such confusional states would be readily detected by physicians or even by lay observers such as family members, and requests for assisted suicide would be appropriately disregarded. In actual practice, however, the detection of judgment-impairing confusion among dying people is surprisingly difficult.[21] Based on several studies of dying patients, one researcher concluded that "our clinical observations miss profound confusional episodes in 20 percent of our patients."[22]

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[20] Neil MacDonald, *Suffering and Dying in Cancer Patients: Research Frontiers in Controlling Confusion, Cachexia, and Dyspnea*, 163 Western J. Med. 278, 280 (1995).

[21] Physicians frequently fail to recognize cognitive impairment in hospitalized patients and may miss delirium because of its fluctuating features and subtle presentation. When physician diagnosis is required to identify cases of delirium, reported rates have been quite low. . . . Although physicians diagnosed delirium in only 8 patients, we found 50 patients (22% of the study population) who met criteria for the disorder . . . In this study of elderly patients on medical services, delirium occurred in over one fifth of subjects and was usually evident within 48 hours of admission. Our prospective surveillance identified many more patients with delirium than were seen by psychiatric consultants or diagnosed by physicians.

J. Francis, et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097, 1098, 1100 (1990).

[22] Eduardo Bruera, *Issues of Symptom Control in Patients with Advanced Cancer*, Mar./Apr. 1993, Am. J. Hospice & Palliative Care, 13.

These results are consistent with more general observations in the SUPPORT study about shortcomings in communications between physicians and dying patients. The SUPPORT study found in Phase I that, of the patients who had expressed preferences for withholding cardiopulmonary resuscitation, "only 47% of their physicians accurately reported this preference." 274 JAMA at 1594. In Phase II, for the intervention group in which a specially trained nurse talked with both physicians and patients on a regular basis regarding patient preferences, among other things, the SUPPORT study found essentially no improvement in physicians' understanding of patients' preferences.

It thus appears that dying patients and their physicians are generally reluctant to talk with one another about matters of profound importance ("discussions and decisions substantially in advance of death were uncommon," 274 JAMA at 1595), and that there are substantial misperceptions between physicians and patients when conversations do occur. (These profound silences and miscommunications between physician and dying patients are often mirrored in general doctor-patient interactions. *See generally* Jay Katz, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).)

This pattern of persistently missed communications appears to confirm the finding that physicians and nurses regularly overstate dying patients' decision-making competence. Whatever the reasons, it is clear that state authorities and medical professional groups face a very difficult task, and currently have inadequate experience or research data, in order to design reliable safeguards to ensure the lucidity of dying patients who might claim a right to assisted suicide.

2. Judgment-impairing depression is common among dying persons and, not surprisingly, is difficult to identify as such.

Distinguishing between a dying person's profound sadness and an appropriate psychiatric diagnosis of clinical depression is exceedingly difficult.[23] For many reasons, however, drawing this distinction with accuracy and sensitivity is important in designing appropriate treatment for all dying people in order to provide the greatest possible satisfactions (for conversations, for reconciliations, for good leave-takings) for them and for their families. Identifying clinical depression is even more important when crucial decisions, such as refusing further medical treatment or requesting assisted suicide, are at stake; clinical depression, which commonly carries deep feelings of personal worthlessness and hopelessness, distorts an individual's rational capacity to make choices.

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[23] [D]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. . . . Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices.

Susan Block & Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 Psychosomatics 445, 451-2 (1995). *See also* Nathan Cherny, et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. Palliative Care 71, 73 (1994) ("Undertreatment [of depression among terminally ill patients] derives largely from the problems of recognition and assessment and from the misconception that depression is a normal response to cancer.").

There has been little systematic research regarding the mental status of dying people who request assisted suicide or refuse life-prolonging treatment. The limited available investigations suggest two propositions: first, that among terminally ill patients "the desire for death could be quite variable over time"; and second, that clinical differentiation between a "psychologically stable" and a distorted decision is "in practice . . . a difficult distinction to make without actually initiating a course of treatment." Harvey Max Chochinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1189-90 (1995).

Safeguards could be designed for the administration of physician-assisted suicide to take account of these considerations. It is not clear, however, that the procedures currently followed in the Netherlands -- the only country with any experience of this legally recognized practice -- do give adequate attention to the related issues of temporal instability and the difficulties of accurate psychiatric diagnosis. As Chochinov, et al. observe, "Although the Dutch guidelines are explicit with respect to the requirement that the request for an assisted death must be persistent over time, it has been reported that in practice, 65% of all euthanasia deaths occur within 2 weeks of the initial request" -- a time span which would be too brief to take account of the "temporal instability of the desire for death that was observed in our group" of patients. *Id.* at 1190.

The Ninth Circuit has specified that, consistent with its finding of a constitutional right to physician-assisted suicide, a state may adopt regulations requiring "reasonable, though short, waiting periods to prevent rash decisions." 79 F.3d at 833 (emphasis added). Would that court consider a two-week waiting period too short, just right, or too long to give adequate respect to a dying person's constitutional right to make a voluntary, mentally competent choice for physician-assisted suicide? There is today insufficient practical

experience and empirical research for rendering any confident judgment on the lapse of time necessary to assure that an individual's decision is not "rash" or clouded by depression or other psychiatric illness. This is yet another uncertainty that attends the administration of physician-assisted suicide, and yet another reason that it is premature for courts to take constitutional command of this issue.

C. Prognosis of Terminal Illness

Both of the courts below explicitly limited the constitutional right for assisted suicide to "terminally ill" people. Both courts were confident, moreover, that reliable identification of "terminally ill" people would not be especially difficult. The Second Circuit stated, "[I]t seems clear that most physicians would agree on the definition of 'terminally ill,' at least for the purpose of the relief that plaintiffs seek." 80 F.3d at 731. The Ninth Circuit stated that "the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined." 79 F.3d at 831.

Both courts are correct that physicians in various contexts are required to determine whether a patient has a "terminal illness." For example, for purposes of admission to hospice programs and eligibility for the Medicare hospice benefit, a patient must be diagnosed as likely to die within six months. There is, however, a substantial degree of uncertainty that attends this prognosis.[24]

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[24] *See* Joanne Lynn, *Caring at the End of Our Lives*, 334 N. Eng. J. Med. 201 (1996). Even though various objective scales for assessing terminal prognoses have been developed in recent years, in order to supplement the more subjective evaluations that individual physicians have always made, it is nevertheless true that all of these judgments remain uncertain. "[T]he pace of dying is affected by many factors over a substantial period of time. . . . Prognosticating will always be inescapably difficult." Joanne Lynn, et

(Continued)

Whatever the justifications for using "terminal illness" predictions in medical decisionmaking, there are special problems that arise when courts use statistical reasoning in determining whether an individual does or does not have a constitutional right. The use of "terminal illness" by the courts below serves to exclude people from exercise of what is held to be a constitutional right.

If a state legislature were to enact such a predictive criterion for excluding people from the exercise of a constitutional right, courts would not hesitate to overturn this restriction on grounds of overinclusive and underinclusive violations of strict scrutiny review. To predict accurately that 100 individuals have a 50% chance of dying within six months, for example, means that in the aggregate 50 of them will die and 50 will not, but it is impossible to determine whether a given individual will be among the living or the dead at the end of the six month period. Accordingly, it is overinclusive to award the constitutional right for choosing assisted suicide to the surviving half of these 100 people. At the same time, the predictive model cannot definitively establish that no one except these 100 individuals with similar

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al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 Western J. Med. 250, 251 (1995). "[N]o matter how sophisticated they become, objective probability estimates represent substantial simplifications of very complex systems." William Knaus, et al., *Short-Term Mortality Predictions for Critically Ill Hospitalized Adults: Science and Ethics*, 254 Science 389, 393 (1991). "The [predictive] models produce *probability estimates*. They are developed and validated on large patient populations. . . . They have not been validated for *individual* patient decisions. . . . [W]e are far from achieving the goal of using individual patient level predictors to make difficult and painful decisions regarding . . . critically ill patients." George Thibaut, *The Use of Clinical Models for 'End of Life' Decisionmaking in Critically Ill ICU Patients*, Summary of Committee Views and Workshop Examining the Feasibility of an Institute of Medicine Study of Dying, Decisionmaking, and Appropriate Care, 13:pp.1-3 (1994).

prognostic characteristics will die of a given disease within six months. Accordingly, it is underinclusive to exclude from the constitutional entitlement people with statistically better prognoses who will in fact die during the six-month period.

If courts refrain from proclaiming a constitutional right in this matter, state legislatures could adopt laws restricting physician-assisted suicide to "terminally ill" people without transgressing the mandate of strict scrutiny. The new Oregon enactment does limit its authorization for assisted suicide to adults "suffering from a terminal disease," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." OR. REV. STAT., tit. 13, ch. 127, §§ 2.01, 1.01(12). Courts have held that, in the absence of any infringement on constitutionally protected liberties, such restrictions are valid exercises of legislative authority. *See Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955).

This cautiously incremental methodology is readily available to legislatures but not to courts in constitutional adjudication. A court is not free to pronounce constitutional rights by selecting only "one phase of one field . . . [while] neglecting the others" any more than a legislature would be free to enact arbitrary limits on the availability of court-proclaimed constitutional rights. *Id.* Regarding physician-assisted suicide, moreover, this "one step" for terminally ill people has been taken thus far only by one state. As Justice Brandeis observed in *New State Ice Co.*, "it is one of the happy incidents of the federal system" that this one state can act "without risk to the rest of the country." 285 U.S. at 311.

The very fact that the courts below felt compelled to limit the reach of their proclaimed constitutional right to this inherently imprecise and individually indeterminable category of the "terminally ill" itself demonstrates their implicit understanding that reform in this sensitive and uncertain area

should proceed "one step at a time." The patent unsuitability of this category in constitutional adjudication itself demonstrates that the entire subject-matter of physician-assisted suicide is, at this early moment in public and legislative deliberations about it, not ripe for constitutional resolution.

CONCLUSION

There is no practical experience in any state with the administration of legally recognized physician-assisted suicide, even in the one state where it has only recently been legislatively approved. Although the courts below in the instant cases held that a constitutional right to physician-assisted suicide must be limited only to voluntary, mentally competent, terminally ill people, there are serious questions -- which cannot be answered based on currently available knowledge and experience -- about whether any of these limitations can be adequately determined in practice. Until additional practical experience and systematic research occurs regarding these questions -- in the "laboratories of the states" -- it would be premature to declare whether or not there is a federal constitutional right to physician-assisted suicide. Accordingly, the decisions of the courts below should be reversed on the ground that the issue presented was not ripe for constitutional adjudication.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,
Respondents,

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, *et al.*,
Respondents

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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QUESTIONS PRESENTED

1. Should this Court invent a constitutional right, without support in either constitutional text, history, or tradition, that would prevent a state from prohibiting a person from hiring another to assist in committing suicide?

2. Does the Equal Protection Clause require states to treat identically the act of refusing possibly useless medical treatment or nutrition and hydration and the act of affirmatively requesting and providing assistance for the purpose of intentionally committing suicide?

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Nos. 95-1858 and 96-110

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,

Respondents,

STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, *et al.*,

Respondents

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

BRIEF AMICUS CURIAE OF THE AMERICAN CENTER FOR LAW & JUSTICE SUPPORTING PETITIONERS IN NOS. 95-1858 AND 96-110

INTEREST OF AMICUS

The American Center for Law and Justice ("ACLJ") a national, non-profit, legal organization, and the ACLJ's human life litigation and education project, the New Hope Life Center, are devoted to safeguarding the sanctity of human life through education, litigation, legislative assistance, and related activities, and have advocated for the defense of human life in local, federal, and state courts. The ACLJ's Chief Counsel has argued several cases before this Court, including *Lamb's Chapel v. Center Moriches Union Free School District*, 508 U.S. 384 (1993), *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), and *Schenck v. Pro-Choice Network*, No.

95-1056 (argued October 16, 1996). In addition, the ACLJ has filed briefs as counsel for parties in several other cases before this Court, including *National Organization for Women, Inc. v. Scheidler*, 510 U.S. 249 (1994), and *Madsen v. Women's Health Center*, 114 S.Ct. 2516 (1996).

The ACLJ files this brief in support of the petitioners in both *Quill* and *Glucksberg* because the courts of appeals' holdings in those cases strike at the heart of the states' long-recognized duty to protect the sanctity of human life. The ACLJ supports the petitioners' contentions in both cases that state laws outlawing assisted suicide are fully consistent with the United States Constitution.*

SUMMARY OF ARGUMENT

1. The Ninth Circuit's decision that Washington's assisted suicide law is unconstitutional because the Due Process Clause creates a right to determine "how and when" to die is dangerously wrong for several reasons. *First*, Washington's law prohibiting assisted suicide rationally furthers the legitimate interest of protecting human life. *Second*, the asserted right has no basis in the Constitution's text or this nation's history and tradition. *Third*, a right to determine "how and when to die" based on the broad, existentialist notion of liberty defined in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), is not susceptible to principled limitation. If liberty is the "right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" such that the

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*. The parties in both cases have consented to the filing of this brief. Letters of consent are being filed with the Clerk of this Court.

Constitution protects self-defining "intimate and personal choices," *id.* at 851, then liberty must include the right to kill oneself, to have a doctor's or somebody else's help in killing one's self, or to have a doctor or somebody else actually do the killing. All of these involve "intimate and personal choices" concerning a person's "concept of existence." But, if liberty is broad enough to include all these choices concerning how and when to die, then it must be broad enough to encompass many other "intimate and personal decisions." Adopting *Casey's* existentialist notion of liberty as a generally-governing constitutional standard would lead to claims of right to use drugs, and to engage in polygamy, fornication, adultery, divorce, sodomy, bestiality, and consensual sadism. If a person has a constitutional right to have somebody kill him, how can he not have a constitutional right to allow somebody to inflict pain and injury on him?

Casey's existentialist notion of liberty provides no principled basis for distinguishing which of these acts to approve and which to disapprove. Extending that notion of liberty will lead to one of two results: either the courts will require states to approve of much conduct the states may reasonably desire to prohibit as harmful, in effect imposing a constitutionally-mandated moral philosophy on the states; or the courts will arbitrarily pick and choose which activities the states may prohibit, and which activities the states must allow. In effect, the courts will become superlegislatures passing on the wisdom of state laws. This would be a rerun of *Lochner v. New York*, 198 U.S. 45 (1905), which imposed a constitutionally mandatory economic philosophy on the states, and established the courts as the final arbiters concerning the wisdom of state laws touching on "economic liberty."

To avoid these dangers, this Court should either overrule *Casey* or decline to extend *Casey's* definition of liberty. There is good reason to think that *Casey's* authors did not intend a radical extension of *Casey's* definition of liberty to uphold alleged rights like the right to assisted suicide. First, the Court in *Bowers v. Hardwick*, 479 U.S. 186 (1986), rejected a similar notion of liberty put forth to establish a right to commit homosexual sodomy; nothing in *Casey* purports to overrule *Bowers*. Second, the *stare decisis* concerns *Casey* found controlling do not exist in this case. Therefore, this Court should refuse to extend *Casey's* definition of liberty to create a right to assisted suicide.

2. The Washington and New York laws prohibiting assisted suicide do not violate the Equal Protection Clause. Suicide is an act performed for the purpose of causing one's death. By definition, those who are affected by the Washington and New York laws are seeking assistance for the very purpose of killing themselves. Since a state may conclude rationally that suicide is wrong and ought to be prohibited, a blanket prohibition of assisted suicide is rational.

However, persons seeking withdrawal of medical treatment or medically-assisted hydration and nutrition are not necessarily committing suicide. Some are, but many if not most are acting for morally licit reasons – for example, to avoid unduly burdensome or possibly useless bodily intrusions – and only accept death as a known but unintended side effect of that decision. To prohibit all decisions to withdraw medical treatment or medically-assisted hydration and nutrition would further the goal of preventing suicide, but would also sweep in much conduct aimed not at directly causing death but at alleviating needless burdens and suffering, conduct that is not

suicide. A state may rationally conclude that the benefits of preventing suicides outweigh the burdens to those not committing suicide; but the state also could rationally conclude that the burdens outweigh the benefits, and decide not to prohibit withdrawals of medical treatment or medically-assisted hydration and nutrition. Since the state has a rational basis for distinguishing these cases from direct, active, assisted suicide, the state may treat the two situations differently.

ARGUMENT

I. THE EXISTENTIALIST NOTION OF LIBERTY POSITED IN THIS COURT'S ABORTION JURISPRUDENCE IS FAR TOO SWEEPING TO SERVE AS A GENERAL RULE FOR CONSTITUTIONAL ADJUDICATION AND OUGHT NOT BE EXTENDED TO CREATE A RIGHT TO ASSISTED SUICIDE.

A. Neither Constitutional Text, Tradition, nor History Support any Fundamental Right to Assisted Suicide.

Ever since repudiating the substantive due process approach of *Lochner v. New York*, 198 U.S. 45 (1905), this Court generally has limited its review of most state laws under the Due Process Clause to determine only whether those laws rationally serve a legitimate state objective. See, e.g., *Nebbia v. New York*, 291 U.S. 502 (1934); *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955); *Bowers v. Hardwick*, 478 U.S. 196 (1986). Certainly, protecting human life is a legitimate government end. That was the view of this nation's founders, who wrote in our founding document that one of the reasons

governments are founded is to secure the "unalienable" right to life. Declaration of Independence, para. 2 (U.S. 1776). Prohibiting assisted suicide rationally furthers this end. Besides helping to preserve the potential suicide's life, a ban on assisted suicide helps to, among other things, "preserve the moral ecology" in a community by preventing bad example which others may emulate, while "educat[ing] people about moral right and wrong" (in this case, the moral "right" of protecting human life and the moral "wrong" of killing). See Gerard V. Bradley, *Pluralistic Perfectionism: A Review of* Making Men Moral, 71 Notre Dame L. Rev. 671, 681 (1996) (reviewing Robert P. George, *Making Men Moral* (1993), and discussing George's argument concerning the legitimate ends served by so-called "morals laws").

Of course, this analysis depends on a state's authority to accept and apply the proposition "suicide is wrong (or harmful)" as a governing proposition for lawmaking. Certainly this proposition is rational (unless one is prepared to dismiss this nation's entire legal history and tradition concerning suicide as irrational). But the respondents in these cases, in effect, seek to deny the states the authority to accept and apply this proposition by positing that the due process clause creates a "fundamental right" to assisted suicide that the state may infringe only upon showing that the infringement is narrowly tailored to serve a "compelling state interest." See *Reno v. Flores*, 507 U.S. 292, 301-03 (1993).

As the Second Circuit correctly observed, the right to suicide, assisted or otherwise, (like the right to "economic liberty" or "freedom of contract" found in *Lochner*) appears nowhere in the Constitution's text. *Quill v. Vacco*, 80 F.3d 716, 723 (2d Cir. 1996). It is true that this Court has granted

heightened protection to "rights" that do not appear in the Constitution's text. The danger in this approach, however, is that it puts the Court in the same position that it occupied during the *Lochner* era–that of a superlegislature substituting its notion of wise public policy for that of the people's elected legislators. Thus, this Court has noted that it "is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986); see also *Michael H. v. Gerald D.*, 491 U.S. 110, 122 (1989) (plurality opinion).

Because of this danger, this Court generally "has been reluctant to expand the concept of substantive due process." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). To limit the proliferation of judge-made rights, this Court has granted heightened protection only to those asserted freedoms that are "'implict in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [they] were sacrificed.'" *Bowers*, 478 U.S. at 191-92 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937)). In determining what asserted freedoms are "implicit in the concept of ordered liberty," the Court generally has turned to history and tradition, according fundamental status only to those asserted freedoms "deeply rooted in this nation's history and tradition." *Id.* at 192 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.)); see also *Michael H.*, 491 U.S. at 122 (fundamental liberties are those "traditionally protected by our society"); *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (Due Process Clause grants only those protections "so rooted in the traditions and conscience of our people as to be ranked as fundamental").

This Court's reliance on history and tradition is at bottom an act of profound judicial humility that serves the end of collective self-government. For the Court to assert without fairly explicit textual support that the Constitution affords fundamental protections to activities that the people and their elected legislators historically have restricted or even prohibited would negate the people's authority to govern themselves by laws of their own making.

As the Second Circuit recognized in *Quill,* 80 F.3d at 724-25, and as Justice Scalia demonstrated in his concurring opinion in *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261, 292-95 (1989), the asserted right to commit suicide, on which the derivative right to assisted suicide depends, flunks the history and tradition test. This brief will not rehash the two cases' discussions. It suffices to say that the English Common Law received in this country prohibited assisted suicide, and the states generally have felt free, both before and after the Fourteenth Amendment's ratification, to prohibit suicide, attempted suicide, and assisted suicide. See *Cruzan*, 497 U.S. at 294-95 (Scalia, J., concurring); *Quill*, 80 F.3d at 724. See generally Thomas Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1 (1985).[1]

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1. Unlike Justice Scalia in *Cruzan,* the Second Circuit in *Quill*, and the majority of the original panel in *Glucksberg,* the majority of the en banc Ninth Circuit found the historical record "checkered." *Compassion in Dying v. Washington,* 79 F.3d 760, 806 (9th Cir. 1996) (en banc). We leave to the petitioners and other amici the task of refuting in detail the Ninth Circuit's peroration on the philosophical and theological history of suicide in western culture. We note only that the Ninth Circuit's discourse is largely tendentious (particularly in its treatment of Christian teaching about suicide, and most notably its ridiculous assertion that the New Testament treats Judas' suicide as an act of *repentance)* and, in any event, beside the point.

B. The Definition of "Liberty" Stated in *Planned Parenthood v. Casey* Should Not be Extended to Create a Right to Assisted Suicide.

That the asserted right to assisted suicide appears nowhere in the Constitution's text and fails the test of history and tradition ought to be a sufficient reason to reject that "right" as one entitled to heightened constitutional protection. The Second Circuit correctly reached that conclusion. See *Quill,* 80 F.3d at 724-25.

Unfortunately, adherence to history and tradition have not always marked this Court's course when deciding to create non-textual constitutional rights entitled to special protection. The primary area in which this Court largely has abandoned its usual caution in creating such rights is the area of abortion. In *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973) this Court overturned all fifty states' abortion laws by finding a right to abortion throughout nine months of pregnancy, despite the fact that neither constitutional text nor our nation's history and tradition supported such a right. *Roe* premised the abortion right on a more general "right to privacy" in childbearing decisions that it culled from earlier cases, particularly, *Griswold v. Connecticut*, 381 U.S. 479 (1965).[2]

Certainly, the Second Circuit in *Quill* was not impressed by Judge Reinhardt's historical scholarship.

2. Neither *Griswold* nor any of its predecessor cases (for example, *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)) support the right created in *Roe*. All those cases were aimed at protecting the integrity of the family *unit,* not some general individual right to make decisions concerning child bearing. *Griswold,* which struck down a Connecticut law prohibiting married couples' *use* of

This Court subsequently reaffirmed what it held to be *Roe's* "central holding" in *Planned Parenthood v. Casey,* 505 U.S. 833 (1992). *Casey* grounded the abortion right on the Due Process Clause guarantee of liberty, see *id.* at 846-53, which it defined in relation to the Court's abortion, contraception, and familial privacy cases as follows:

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the right to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." These matters, *involving the most intimate*

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contraceptives, was premised expressly on the need to protect the privacy that the good of marital intimacy requires, and the damage to that privacy that Connecticut's ban on contraceptive use could do. See 381 U.S. at 484-86 (opinion of the Court); *id.* at 493-96 (Goldberg, J., concurring); *id.* at 507 (White, J., concurring). See also *Poe v. Ullman*, 367 U.S. 497, 553 (1961) (Harlan, J., dissenting). Tellingly, Justice Harlan's dissent in *Poe* distinguished Connecticut's contraceptive ban, which he said unconstitutionally imposed on the goodof marital intimacy, from subjects such as abortion, euthanasia, and suicide, which he said statescould restrict. See *Poe,* 367 U.S. at 545-53 (Harlan, J., concurring). For more extended discussion of the transmogrification of the marital/familial privacy right recognized in *Griswold* into the individual right created in *Roe*, see David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court,* 75 Marq. L. Rev. 975, 1059-64 (1992); Gerard V. Bradley, Life's Dominion: *A Review Essay,* 69 Notre Dame L. Rev. 329, 350-58 (1993); David Wagner, *The Family and American Constitutional Law*, 1 Liberty, Life& Fam. 145,157-67 (1994).

> *and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.*

Id. at 851 (citations omitted; emphasis, except for "*individual*," added).

Casey's conception of liberty formed the linchpin of the Ninth Circuit's decision in *Glucksberg.* The Ninth Circuit en banc majority seized on the italicized language quoted above and concluded that, because "the decision how and when to die 'is one of the most intimate and personal choices a person may make in a lifetime'" that decision "[s]urely...implicates a most vital liberty interest." *Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996) (en banc). The Ninth Circuit held that no asserted interest justified the state in prohibiting "competent, terminally ill adults" from seeking a physician's assistance in committing suicide. *Id.* at 840.

Admittedly, the Ninth Circuit's extension of *Casey* has a surface logic. If liberty *really* means, as a general constitutional rule, "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," then what the Court recognized in *Casey* is nothing less than a constitutional right to creat[e] one's own moral universe. In fact, the very word "autonomy," which the quoted passage from *Casey* expressly ties to "the liberty protected by the Fourteenth Amendment," 505 U.S. at 851,

"derives from the Greek 'auto' for self and 'nomos' for law, so that it can be literally defined as being a law for, or unto, oneself." David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 Marq. L. Rev. 975, 981 (1992) (citing I *Oxford English Dictionary* 807 (Clarendon Press, 2d ed. 1969)). If *that* is liberty, how can liberty *not* include the right to commit suicide (or as the Ninth Circuit delicately put it, the right to choose "how and when one dies") even with a physician's assistance (or anybody else's assistance, for that matter)?

The Court should resist this logic. *Casey* appears to say that unconstrained choice "define[s] the attributes of personhood." *Casey*, 505 U.S. at 851. If so, then *Casey* has made Jean-Paul Sartre's existentialist philosophy this nation's constitutionally-mandated moral philosophy. The existentialists taught that the human person creates and defines himself by the choices he makes, as summed up in the slogan "existence precedes essence." Jean-Paul Sartre, *Existentialism* 15 (Bernard Frechtman trans., 1947). In other words, choosing is more important than being. Thus, in the existentialist view, "freedom is characterized by a constantly renewed obligation to remake the *Self*," an obligation fulfilled by making self-defining and self-creating choices. Jean-Paul Sartre, *Being and Nothingness* 34-35 (Hazel E. Barnes trans. 1956). See generally Smolin, *The Jurisprudence of Privacy*, 75 Marq. L. Rev. at 980-84.

Of course, the Constitution no more enacts M. Jean-Paul Sartre's *Existentialism* as this nation's governing moral philosophy than it enacted "Mr. Herbert Spencer's Social Statics" as the nation's governing economic philosophy. *Lochner*, 198 U.S. at 75 (Holmes, J., dissenting). In any event,

making *Casey's* existentialist definition of liberty the generally governing constitutional standard would have consequences the *Casey* Court may well not have foreseen. For instance, it reasonably follows from tying "the attributes of personhood" to the ability to "define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," *Casey*, 505 U.S. at 851, that the inability to make this self-definition must be the antithesis of personhood. If so, those without sufficient cognition to make this self-definition are not persons. Since protection under the Fourteenth Amendment's Equal Protection and Due Process Clauses depends on one's status as a "person," the notion that personhood depends on cognition sufficient to allow a being to define his own concept of existence throws considerable doubt on the constitutional status of infants, small children, the mentally retarded, the mentally ill, the mentally incompetent, the comatose, and the unconscious. The joint opinion's notion of personhood as the ability for self-definition through conscious choice echoes the writings of ethicists who have excluded from the ranks of personhood those who lack what the ethicists judge to be sufficient rationality and self-consciousness.[3]

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3. See, e.g., Joseph Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, 2 Hastings Center Rep. (Nov.1972) (adopting, among other criteria for humanity, self-awareness, ability to communicate, and a minimum IQ of 20, and questioning the humanity of anyonewith an IQ less than 40); Peter Singer, *Practical Ethics* 76, 97 (1979) (proposing that a "person" is a rational and self-conscious being: "So it seems that killing, say a chimpanzee is worse than the killing of a gravely defective human who is not a person"). See generally William Brennan, *Dehumanizing the Vulnerable* 152-56 (1995) (collecting the similar views of other ethicists). See also Bradley, Life's Dominion, 69 Notre Dame L. Rev. at 374-80 (summarizing and critiquing Ronald Dworkin's view of personhood and the

Moreover, a right to assisted suicide based on *Casey's* notion of liberty would be impossible to limit in any principled way. *Glucksberg* and *Quill* concerned the right of "terminally ill" competent adults to receive a physician's assistance in committing suicide. But why limit the right to terminally-ill patients? What of the quadriplegic, consigned to life in a wheelchair? What of the person consigned to suffer lifelong pain from a condition that will not kill him? How much physical suffering and pain are too little to justify a right to suicide? And why are federal courts, including this Court, more competent than the people's elected representatives to make that decision?

An even more basic question arises: If liberty is "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," why should the assisted suicide right be limited by life expectancy or physical or emotional pain and suffering? "To be, or not to be"[4] would seem to be the fundamental decision *any* person would face in defining his own "concept of existence." If *Casey's* notion of liberty does include the right to define one's own concept of existence, an assisted suicide right based on *Casey* "must be the prerogative of at least every sane adult." *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (1995). See generally Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide–and Why These Reasons are not Convincing*, 12 Issues in Law & Med. 113, 128-30 (1996).

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morality of killing).

4. William Shakespeare, *Hamlet*, act 3, sc.1 (Harvard Classics, Charles W. Elliott ed. 1938).

Moreover, a right to physician-assisted suicide would inevitably become a right to physician-administered voluntary euthanasia in some cases. Even the en banc Ninth Circuit recognized that physicians or their agents might have to actually kill the patient when the patient cannot kill himself. *Compassion in Dying v. Washington*, 79 F.3d 790, 832 (9th Cir. 1996) (en banc).[5] While the Ninth Circuit speculated that the Constitution might treat such voluntary euthanasia differently than physician-assisted suicide, the court candidly acknowledged that the key question is not who kills the patient, but rather who decides to kill. *Id.* at 831-32. This reflects the existentialist notion that the ability to choose consciously is the essence of personhood and liberty. If this notion controls, it would be arbitrary to confine to those who can pull the trigger or administer the deadly potion themselves the right to define their own "concept of existence" by ending that existence. It would be just as arbitrary to confine that right to those who choose to pay a physician to administer the means of death. If the *choice* to die is what matters, how can a court reasonably limit the choice to being killed by a doctor?

This raises the spectre that the Constitution could mandate that the victim's consent be a defense to homicide. The law generally has not regarded consent to be a complete defense to

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5. The Ninth Circuit refused to call this act of killing another "euthanasia," preferring instead to categorize this act along with assisted suicide as "volitional death." See 79 F.3d at 832 & n.120. However, there is no other more proper term for this killing: "euthanasia" *means* "the action of killing an individual for reasons considered merciful." *The American Heritage Dictionary* 469 (2d College ed. 1991). The Ninth Circuit's word play is itself a form of killing–"the murder of a word," which C.S. Lewis called "verbicide." C.S. Lewis, *Studies in Words* 7 (2d ed. 1967).

homicide. See Wayne R. LaFave and Austin W. Scott, *Handbook on Criminal Law* § 57, at 408 (1972). But if doctors are immune from homicide charges for executing a patient's request to be killed, why should not other "angels of mercy" be similarly immune (or at least able to raise consent as a defense at trial)? One might object that such a consent defense would raise evidentiary problems that might not arise when physicians perform voluntary euthanasia. Even if this were true, states could overcome those evidentiary problems by means other than completely prohibiting nonphysicians from performing voluntary euthanasia. Cf. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1989) (upholding a Missouri law requiring "clear and convincing" evidence of an incompetent's wishes before authorizing withdrawal of hydration and nutrition). To ban nonphysicians other than doctors from killing a consenting victim would under the existentialist view arbitrarily limit the ability of a person who cannot afford or does not desire *physician*-assisted death to define his own concept of existence by choosing to end that existence as *he* sees fit.

Connecticut v. Menillo, 423 U.S. 9 (1975) (per curiam), which held that *Roe v. Wade* did not prevent states from enforcing criminal abortion statutes against nonphysicians, is not to the contrary. *Menillo* was premised on the state's interest in preserving maternal health; abortion by physicians is likely to be safer for the mother than abortion by nonphysicians. *Id.* at 10-11. This does not distinguish euthanasia by physicians from killing by nonphysicians. While it may take some medical expertise to perform an operation that kills an unborn child while leaving the mother unharmed (or at least alive), it takes no medical expertise to put a gun to

somebody's head and pull the trigger, or perform the sundry other acts that would kill another.

Some might suggest preventing unnecessary pain as a reason for allowing only doctors to kill. But this aesthetic concern provides no reason to limit a person's right to choose a violent and painful death if that person really has a right to choose "how and when" he dies, *Compassion in Dying*, 79 F.3d at 838, based on a right to define his "own concept of existence, of meaning, of the universe, and of the mystery of human life." Self-loathing is as much a concept of existence and meaning as self-love. One person chooses a painless death; another chooses a painful death; *Casey's* definition of liberty implies that the state is not competent to judge the relative merits of the concepts of existence and meaning that led to those choices.

Finding principled limits to *Casey*-style liberty is not confined to the problem of limiting a right to assisted suicide. Adopting *Casey's* existentialist definition of liberty as a general constitutional standard will inevitably lead to claims of right to engage in sundry other activities besides suicide. These activities could well include drug use, polygamy, fornication, adultery, divorce, prostitution, sodomy, bestiality, and consensual sadism. All these can be said to be "intimate and personal choices" that arise from the person's "concept of existence, of meaning, of the universe, and of the mystery of human life." State prohibitions of these activities would prevent those who would choose to engage in these activities from "defin[ing] the attributes of [their] personhood" as surely as state prohibition of assisted suicide.

Some would scoff at this "parade of horribles." But a "reading of 'the right to define one's own concept of existence'

language broad enough to cover assisted suicide would be broad enough to cover a great many other things. It would surely cover the autonomy of sexual activity and relationships, and it would do so more easily than it would embrace assisted suicide." Yale Kamisar, *Against Assisted Suicide–Even a Very Limited Form*, 72 U. Det. Mercy. L. Rev. 735, 767 (1995).

Take divorce, for example. Certainly, the choice to marry is among "the most intimate and personal choices a person may make in a lifetime." *Casey* 505 U.S. at 851. But the choice to *dissolve* one's marriage also is an intimate and personal choice. Taking *Casey* at its word, and accepting that liberty involves the right to "define the attributes of personhood" by making such choices, a right to divorce necessarily follows. Indeed, Kenneth Karst, applying a supposed right to "intimate association" that is similar if not identical to *Casey's* notion of liberty as the right to unconstrained choice, concluded in 1980 that a constitutional right to no-fault divorce exists. Kenneth L. Karst, *The Freedom of Intimate Association*, 89 Yale L .J. 624, 637-38, 671-72 (1980); see also Smolin, *The Jurisprudence of Privacy*, 75 Marq. L. Rev. at 984 (discussing Karst's theory of intimate association).

As another example, suppose Timmy's "concept of existence, of meaning, of the universe" leads him to conclude that he should "marry" Lassie. If *Casey* meant what it said about liberty, how could the state interfere with Timmy's self-defining choice to pursue this "intimate association"? One might say that our society traditionally has prohibited bestiality. But our society traditionally has prohibited abortion and suicide as well. See Robert M. Byrn, *An American Tragedy: The Supreme Court and Abortion*, 41 Fordham L. Rev. 807, 814-35 (1973) (discussing the history of abortion

prohibition); *Quill v. Vacco,* 80 F.3d 716, 724 (2d Cir. 1996) (discussing historical prohibition of suicide). One might say the state may act to prevent harm to Timmy. But that would be a strange basis for regulating Timmy's conduct with Lassie when Timmy has the right to kill himself or have himself killed.[6] One might say the state may act to prevent harm to Lassie. But that would be an absurd basis for upholding the state's action: the state may prohibit bestiality to prevent harm to animals, but may not prevent humans from harming or even killing themselves (or allowing others to harm or kill them). Moreover, if *Casey's* conception of liberty prevents the state from prohibiting the destruction of a being that is likely a human being, how can that conception of liberty allow a state to prevent a person from having "intimate relations" with a dog?

These examples demonstrate that establishing *Casey's* existentialist definition of liberty as a general constitutional standard could require states to allow conduct the states may well desire to prohibit as harmful, and that the states traditionally have had the authority to prohibit.[7] This, in effect,

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6. This would also seem to preclude prohibitions of consensual sadism. If somebody has the constitutional right to allow another to kill him, on what basis may the state prohibit that person from allowing another to inflict pain on him?

7. *Casey's* notion of liberty may also put in doubt the constitutionalty of such mundane laws as laws requiring automobile passengers to wear seat belts or motorcycle riders to wear helmets, as well as other laws, such as consumer protection laws and FDA regulations, that restrict autonomous choice. *My* concept of meaning requires me to live dangerously; under *Casey*, who is the state to tell me I cannot choose to live dangerously when the state cannot prevent me from intentionally killing myself?

would impose a radical constitutionally-mandated moral philosophy–existentialism–on the states. This is a rerun of *Lochner*, which imposed a constitutionally-mandated economic philosophy on the states. Jean-Paul Sartre's *Existentialism* simply replaces Mr. Herbert Spencer's Social Statics as the Court's mandated philosophy of choice.

Of course, recognizing a right to assisted suicide based on *Casey's* existentialist notion of liberty may not inevitably lead the Court to invalidate laws prohibiting or "unduly" restricting divorce, bestiality, or consensual sadism (or laws prohibiting other consensual activities the law traditionally has prohibited). The Court could reject all these claims or accept some or reject others. It could decide to impose certain "reasonable" conditions on the exercise of choice concerning these matters. But an existentialist notion of liberty as the right to unconstrained choice concerning intimate and personal matters provides no principled grounds for making these decisions. Decisions will necessarily rely on ad hoc and essentially arbitrary judgments: Which decisions are "personal and intimate" enough to fall within *Casey's* definition of liberty? Are some people's concepts "of existence, of meaning, of the universe, and of the mystery of human life" more or less worthy than others? When are the state's or society's interests sufficient to justify constraining choice given the importance the Court sees in the asserted choice?

This ad hoc process would significantly intrude on the people's right to collective self-government. The process would establish the courts as superlegislatures, passing not only on the constitutionality of states' laws, but also–as can be seen from the questions the courts must consider–on those laws' wisdom. Courts, not elected legislators subject to the people's

ultimate control, will decide which laws the people shall be governed by, despite the lack of any express basis for decision in constitutional text or our nation's tradition, and despite the fact that courts are no better situated or qualified to weigh the competing interests at stake.

This is the vice that infected *Lochner's* substantive due process approach. Contrary to popular perception, during the *Lochner* era, "most challenged laws withstood attack." Gerald Gunther, *Constitutional Law* 445 (12th ed. 1991). Yet, *Lochner* represented a significant intrusion on collective self-government precisely by imposing on the states an economic philosophy found nowhere in the Constitution. *Lochner* thus established the courts, and not the states' legislatures, as the ultimate arbiters concerning laws that were reasonable exercises of the states' traditional authority.

To avoid these dangers, the Court should not extend *Casey's* definition of liberty outside the context in which it appeared to create a right to assisted suicide. Of course, one might say that a decision not to so extend *Casey* is itself arbitrary since this Court's abortion jurisprudence suffers from the *Lochner*-style flaws we have just outlined. See generally *Casey,* 505 U.S. at 979-1002 (Scalia, J., dissenting). Therefore, overruling *Casey* would be the most principled way to stanch the dangers that flow from its existentialist notion of liberty. But if the Court is unwilling to overrule *Casey*, "[t]he device of compartmentalizing precedent is an old jurisprudential strategy for limiting unruly doctrines." Kamisar, *Against Assisted Suicide,* 72 U. Det. Mercy L. Rev. at 764. Nothing requires a court to extend bad doctrine further than that doctrine already extends.

In any event, there is good reason to think that the *Casey* joint opinion's authors did not intend for *Casey's* definition of liberty to become a general constitutional standard. As noted, one would expect a definition of liberty as broad as that in *Casey* to encompass the choice to engage in consensual sodomy. In fact, *Casey's* definition of liberty mirrors Justice Blackmun's argument in *Bowers v. Hardwick*, 478 U.S. 186 (1986), that the Constitution protects a person's right to engage in homosexual sodomy. Compare *Casey*, 505 U.S. at 851 with *Bowers*, 478 U.S. at 204-06. See generally Smolin, *The Jurisprudence of Privacy*, 75 Marquette L. Rev. at 981-84. The Court in *Bowers* rejected Justice Blackmun's argument. Yet, nothing in *Casey* purports to overrule *Bowers*.

Moreover, *Casey* expressly relied on the principle of *stare decisis*, as well as the broad definition of liberty, as reasons for affirming *Roe's* "central holding." See 505 U.S. at 853 ("the reservations any of us may have in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of *stare decisis*"). No previous case of this Court has ever recognized a right to assisted suicide. Therefore, no *stare decisis* concerns exist in this case.[8]

If the Court does not extend *Casey's* definition of liberty, the asserted right to assisted suicide depends for its existence on constitutional text and tradition. As we have shown, neither

8. This is not to say we that agree with *Casey's* application of *stare decisis*, for, in fact, we do not. See, e.g., Jay Alan Sekulow & John Tuskey, *The "Center" is in the Eye of the Beholder*, 40 N.Y. L. Sch. L. Rev. 945, 961-62 (1996). But that does not affect the fact that the *stare decisis* concerns the majority thought controlling in *Casey* do not exist in this case.

text nor tradition support that right. Therefore, the Ninth Circuit's decision creating a right to assisted suicide under the Due Process Clause cannot stand.[9]

II. THE STATE MAY RATIONALLY DISTINGUISH BETWEEN ASSISTED SUICIDE AND REFUSAL OF LIFESAVING TREATMENT OR MEDICALLY-ASSISTED NUTRITION AND HYDRATION; THEREFORE, LAWS TREATING THE TWO SITUATIONS DIFFERENTLY DO NOT VIOLATE THE EQUAL PROTECTION CLAUSE.

The Second Circuit properly rejected the argument that the Due Process Clause creates a right to assisted suicide. *Quill*, 80 F.3d at 724-25. But the Second Circuit held that New York's law prohibiting assisted suicide violated the Equal Protection Clause. *Id.* at 725-31. Essentially, the court found no rational basis for New York to prohibit assisted suicide while allowing withdrawal of life-sustaining treatment and medically-assisted

9. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) does not require a different result. In *Cruzan*, the Court merely assumed "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. Even this assumption was dictum, since *Cruzan* involved an incompetent patient allegedly in a persistent vegetative state. *Id.* at 265. In any event, the Court based its assumption not on any broad existentialist notion of liberty (though such a notion was implicit in the Court's abortion cases, and explicit in Justice Blackmun's *Bowers* dissent, neither of which the Court cited) but rather on cases establishing a person's right to refuse unwanted invasions of his body. See *id.* at 278-79; *id.* at 287-89 (O'Connor, J., concurring). Moreover, in assessing the state's interest in protecting human life, the Court noted approvingly the existence of state laws prohibiting assisted suicide, in no way suggesting such laws might violate the Constitution. *Id.* at 280.

hydration and nutrition. In both cases, according to the Second Circuit, New York allows patients to kill themselves with a doctor's assistance. See *id.*

While the Second Circuit correctly applied rational basis analysis to the New York law because because since neither a fundamental right nor a suspect class are involved in this case, *Heller v. Doe,* 509 U.S. 312, 319 (1993), the Second Circuit erred in both its premise and its conclusion in applying this analysis. Not all (and probably a small minority of) decisions to refuse life-sustaining treatment are suicide; therefore, it is rational to prohibit assisted suicide while at the same time allowing patients to refuse or request withdrawal of life-sustaining treatment.

Suicide is an act performed for the *purpose* of directly causing one's death. But a rational moral distinction exists between suicide and certain acts done with the *knowledge* that death is likely, or even inevitable. For example, a man lying on the railroad tracks waiting for the 9:00 express to put him out of his misery is committing suicide. But a man who sees the train bearing down on his son and rushes onto the tracks to save his son's life knowing full well that he will probably lose his own life in the process is not committing suicide. Nobody would suggest that it is irrational for one who believes suicide is wrong to think of the first act as immoral and the second act as morally permissible.

The people affected by Washington's and New York's assisted suicide prohibitions are by definition seeking assistance for the very purpose of killing themselves. They are, morally speaking, in the first man's position; they are intentionally seeking death. On the premise that suicide is

wrong, no moral gray area exists. Since the state may conclude rationally that suicide is wrong and ought to be prohibited (see *supra*, p.), a blanket prohibition of assisted suicide is rational.

But not all those who refuse or seek withdrawal of medical treatment or medically-assisted nutrition and hydration are intentionally choosing death. Admittedly, some are; but many, if not most people refusing medical treatment "would only be accepting death as a side effect of a choice to give up expensive, possibly useless treatment." Gerard V. Bradley, *Pluralistic Perfectionism: A Review Essay of* Making Men Moral, 71 Notre Dame L. Rev. 671, 684 (1996). This holds even for a decision to refuse medically-assisted nutrition and hydration. As the United States Catholic Bishops noted, "we should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death." *Statement of the USCC Committee for Pro-Life Activities*, 24 Origins 705 (1992). As the Bishops recognized, the patient may be facing imminent death anyway, so that his condition, and not lack of nutrition or hydration, will probably kill him; or, the patient may be acting not for the purpose of killing himself, but for the purpose of avoiding a procedure "of limited usefulness to the patient or unreasonably burdensome for the patient and the patient's family or care giver." *Id.*

Those who refuse or seek withdrawal of medical treatment or medically-assisted hydration and nutrition for a reason other than to kill themselves are, morally speaking, in a similar position to the man who ran onto the tracks to save his son, knowing he would likely die in the rescue. They are not committing suicide; they are only accepting death as a side effect of what may well be a morally licit action. See *id.* ("This

kind of decision should not be equated with . . . suicide"). It is entirely consistent with the principle that suicide is wrong to allow these people to refuse medical treatment or medically-assisted hydration and nutrition.

But what of those who refuse medical treatment or medically-assisted hydration and nutrition for the purpose of killing themselves? Admittedly, such refusal would be suicide. But this does not mean that it is irrational for the state to treat all refusals of medical treatment or medically-assisted hydration and nutrition, as a class, differently than it treats assisted suicide by active means.

It makes sense to prohibit all assisted suicides because all who seek assisted suicide are acting specifically to kill themselves. But the question becomes more subtle when speaking of decisions to withdraw life-sustaining treatment or medically-assisted food and hydration because while some people making this decision intend to commit suicide, many if not most people making this decision do not intend to commit suicide; they merely accept death as a side effect of their action. A state operating under the governing principle that suicide is wrong has several possible rational alternatives. The state could prohibit all withdrawal of life-sustaining treatment. This approach would succeed in vindicating the state's conclusion that suicide is wrong and ought to be banned, but at the cost of prohibiting much behavior that is not suicide. One might conclude that given the legitimate interest a person has in refusing unduly burdensome and potentially useless treatment, this cost is too great.

Second, the state could examine each case to determine which withdrawals of treatment really are suicide and which are

not, and restrict or punish those withdrawals that amount to suicide. But error in assessing "what is, after all, the silent operation of the mind," Bradley, *Pluralistic Perfectionism*, 71 Notre Dame L. Rev. at 684, could lead the state to punish acts that really are not illicit killing. This possibility, in turn, could deter the withdrawal of unduly burdensome and potentially useless treatment when such withdrawal would be justified. It would thus be rational for the state to recognize the limited ability of the law and those who must apply the law to make subtle judgments about the subjective reasoning process, and decide not to pursue this case-by-case approach.

Rejecting those first two options, the state could rationally adopt a third option: do not prohibit withdrawal of lifesaving treatment. That would allow some behavior that amounts to suicide. But it would also avoid the cost of prohibiting or deterring morally licit behavior and prevent the law from becoming embroiled in subtle judgments about intent. A rational person could consider the costs of the first two approaches to outweigh their benefits, and thus settle on this third approach as a reasonable resolution.

Thus, a state adhering to the general proposition that suicide is wrong could rationally decide to prohibit assisted suicide and at the same time allow patients to refuse or request withdrawal of life-saving treatment or medically-assisted hydration and nutrition. That decision requires weighing the costs and benefits of alternative courses of action against the states's paramount interest in protecting human life. In short, that decision is quintessentially a legislative decision; it is not the federal courts' domain.

To reject a state's decision in this area would require courts

either to reject the state's right to adopt a mode of moral reasoning that allows one to make distinctions based on the actor's purpose in acting (which would put much established criminal and tort law in constitutional jeopardy) or to reject the state's balancing of the various interests and related costs and benefits involved. Courts would either have to impose a constitutionally-mandated moral philosophy on the states, or courts would have to judge expressly the wisdom of the state's decision. In either event, courts would unduly infringe legitimate state prerogatives and the people's right to collective self-government. *Lochner*-style judicial second guessing would again rear its ugly head, except this time by way of the Equal Protection Clause rather than the Due Process Clause. The Equal Protection Clause does not require this result.

CONCLUSION

For the reason stated above, this Court should reverse both the Ninth Circuit's decision in *Glucksberg* and the Second Circuit's decision in *Quill*.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON; CHRISTINE O. GREGOIRE, Attorney General of Washington,

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v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

CORRECTED COPY

On Writs of Certiorari to the United States Courts of Appeals for the Second Circuit and for the Ninth Circuit

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BRIEF AMICUS CURIAE FOR THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Are laws prohibiting physician-assisted suicide justified by legitimate state interests?

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BRIEF AMICUS CURIAE FOR THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

The National Hospice Organization ("NHO")[1] is a non-profit, public-benefit, charitable organization dedicated to promoting and maintaining quality care for the needs of terminally-ill persons and their families. Established in 1978, NHO currently represents more than 2,200 hospice programs and 47 state hospice organizations, as well as over 4,000 hospice professionals and supporters.

NHO's organizational mission is to enhance the end of life for people dying in America by ensuring access to quality hospice care. Hospice, in this context, refers not to a place, but rather to a program of care, based on a philosophy that recognizes dying as part of the normal process of living and focuses on enhancing the quality of remaining life. As a central tenet, the hospice philosophy affirms life and seeks neither to hasten nor to postpone death.

A hospice is a coordinated health care program that provides palliative and supportive care to terminally-ill patients and their families, twenty-four hours a day, seven days a week, at home or in home-like facilities. With a focus on enhancing the quality of life for both the patient and the family, hospices provide physical, social, spiritual, and emotional care, using a medically-directed interdisciplinary team consisting of professionals and volunteers. A typical hospice team includes a hospice physician; the patient's attending physician; and one or more nurses, social workers, pastoral or other counselors, home health aides, and volunteers.[2]

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[1] This brief is being filed with the consent of the parties, whose letters of consent have been filed with the Clerk of the Court.

[2] Hospice care is a covered benefit under Medicare, 42 U.S.C. § 1395x(dd), as well as under most other public and private health insurance programs. The Medicare definition of hospice care and conditions of participation for hospice programs form the basis for many state licensure laws and are consistent with NHO's Standards for a Hospice Program of Care.

In order to help patients make the most of the time that remains to them, hospices establish pain control and symptom management as clinical goals. Moreover, hospices understand the need to treat patients' emotional needs as well as their physical requirements and recognize that psychological pain is as significant as physical pain.

Hospices are unique in that they include the patient's family and friends within the unit of care and help family members as an essential part of their mission. Accordingly, hospices provide a wide variety of support for family members and friends while their loved one is dying, as well as bereavement care after the person has died.

The hospice philosophy also affirms the right of those who are dying to make as many choices as possible for themselves—both in living what is left of life and in dealing with fatal illness. An important component of hospice care, therefore, is enhancing the ability of patients to control their lives for as long as possible, even in the terminal phase of their illness. Accordingly, NHO has supported the right of terminally-ill patients to refuse intrusive, life-prolonging treatment or nourishment. Dying patients must have the right to make the choice to refuse interventions designed to prolong the dying process.

NHO does not, however, agree with the courts below that because States must allow terminally-ill people to refuse such unwanted treatments, they must also allow physicians to assist terminally-ill patients to end their lives by suicide. Hospice professionals, who deal with dying patients every day, see these issues as presenting very different risks and benefits to the terminally ill, their families, and society at large.

NHO recognizes that the vast majority of people in this country have strong feelings about issues relating to death. It is a subject affecting us all, and our views are likely to be colored by introspection and fear. It is for that very reason that we must be extremely careful that we use the proper standard for determining the legitimacy of a legislature's conclusions. We should ask ourselves not whether a dying individual has a right, uninhibited by legislative intervention, to choose to have a doctor assist in his suicide, but rather whether the State has a legitimate interest in seeing to it that its citizens be given every opportunity to decide to live, unimpaired by such factors as pain and depression.

It is important, therefore, that this Court be fully aware of a middle ground available between the two extremes of physician-assisted suicide and a death devoid of peace and dignity. In that middle ground is hospice. Without statutes such as those at issue in this case, hospices will have no opportunity to assist persons who simply wish to die become persons wishing to live until they die.

SUMMARY OF ARGUMENT

The decisions below failed to appreciate that the final stage of life presents opportunities for meaningful experiences that could be lost without the State's protection of life and prevention of assisted suicide even among the terminally ill. Moreover, many terminally-ill patients seek assistance with suicide not because they cannot be cured, but rather because they cannot bear the physical pain and depression that often accompany terminal illness. These factors can almost always be ameliorated.

Hospice care provides a proven, effective alternative to assisted suicide that is ideally suited to ameliorate the factors underlying the desire for suicide among the terminally ill. By emphasizing palliative care, the hospice

movement has succeeded in increasing awareness in the medical community of the need to treat pain and symptom management aggressively. Furthermore, hospices understand the psychological dimension of suffering and are committed to treating the depression and fear that surround terminal illness. When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide generally disappears. Hospices provide substantial benefits to the patients' families as well, by including them in the unit of care and by providing them with the counseling, support, and anticipatory grief work that has proven so effective in softening the blow of a loved one's death. Like hospices, States can legitimately place value on the end of life by refusing to support the practice of physician-assisted suicide.

States are also justified in retaining the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The medical literature does not support the confidence of the courts below in the ability of medical professionals to distinguish between those who are and are not in the final stages of a terminal illness, and errors in prognosis would have tragic consequences if they were to form the basis for assisted suicide. Abandoning the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment would also thwart recent efforts to increase awareness in both the medical community and the public of the benefits of the comprehensive program of palliative and supportive care offered by hospices. Finally, acceptance of assisted suicide among the terminally ill would place hospices and other health care providers in an untenable position by diminishing the level of trust between the health care provider and patient that is critical to the provision of effective care. Given the adverse consequences that would flow from the recognition of a right to assisted suicide, this Court should adhere

to the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment.

ARGUMENT

I. THE COURTS BELOW DISMISSED THE STATES' INTEREST IN PRESERVING LIFE BY FAILING TO CONSIDER THE OPPORTUNITIES TO FIND VALUE DURING THE LAST STAGE OF LIFE.

While recognizing the State's interest in preserving the lives of all its citizens, the courts below found that this interest was attenuated when the lives being preserved suffered from terminal illness. As the Second Circuit reasoned:

> [W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? * * * The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

No. 95-1858 Pet. App. 31a (citation omitted). Similarly, the Ninth Circuit found the State's interest in preventing suicides to be "substantially diminished in the case of terminally ill, competent adults who wish to die." No. 96-110 Pet. App. A-73 to A-74. The Ninth Circuit concluded that under such circumstances "the state's interest in preventing such individuals from hastening their deaths [was] of comparatively little weight." *Id.* at A-74; *see also id.* at A-89 (reasoning that the state interest in protecting family members and loved ones "is of almost negligible weight when the patient is terminally ill").

What the courts below failed to recognize is that the final stage of life may be a time of profound opportunity for terminally-ill individuals and their families. The hospice experience has taught that life is not "all but ended" simply because a person suffers from a terminal illness,

nor does "the potential for life diminish[]." Dying is an intrinsic part of being human, and like life's other phases, dying offers unique challenges and opportunities. Given proper support, dying can become an important, valued *life* event. As one commentator has noted, "However diminished the body and however changed the life circumstances in later life, the mind and spirit can still flourish. At all stages of life, even as we are sick and dying, we have the capacity to set new goals, redefine the self, and find valid meaning and integrity in our existence." Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 Issues L. & Med. 415, 433 (1995); *see also* Ira R. Byock, *The Nature of Suffering and the Nature of Opportunity at the End of Life*, 12 Clin. Geriatric Med. 237, 248 (1996).

By treating the end of life as meaningless, the courts below adopted an unnecessarily static view that is unable to accommodate the changing nature of life and of the self. Osgood, 10 Issues L. & Med. at 433. Had these courts acknowledged that dying is a part of the normal process of living and that like all of life's stages it presents substantial opportunities for personal growth and development, they would have recognized that the State has an interest in preserving life even in the face of terminal illness. Instead, the courts below adopted a view of dying which admitted only two possibilities: unrelieved misery or assisted suicide. As the Ninth Circuit reasoned, when all that lies ahead is "debilitating pain and a humiliating death, the decision to commit suicide is not senseless." No. 96-110 Pet. App. A-74. This truncated view of dying ignores the fact that it is almost always possible to ameliorate the factors underlying the desire for suicide among the terminally ill.

Numerous studies have documented that uncontrolled pain is a major risk factor for suicide among the terminally ill. *See, e.g.*, Susan D. Block & J. Andrew Bill-

ings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2040 (1994); *see also Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcomm. on the Const. of the House Comm. on the Judiciary*, 104th Cong., 2d Sess. 10 (1996). Sadly, although such physical suffering can almost always be alleviated, until recently physical pain has been woefully undertreated in this country. *See, e.g.*, Block & Billings, 154 Archives Internal Med. at 2040; Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-293 (1991); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1124 (1996).

Indeed, the undertreatment of pain in terminally-ill patients was one of the factors underlying the development of the first American hospices in the early 1970's. In the intervening decades, however, not only has the hospice movement spread throughout the United States, but, more recently, the organizations that set standards for the practice of medicine have embarked on efforts to educate doctors about palliative care techniques and to encourage appropriate treatment of pain and other symptoms, with the end result that pain should no longer be a cause for ending one's life. Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 9: Management of Cancer Pain* (1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency—Educational Resources Document* (1996).

Depression is another factor that renders terminally-ill patients vulnerable to thoughts of assisted suicide. *See, e.g.*, William Breitbart *et al., Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 239, 241 (1996); Foley, 6 J.

Pain & Symptom Mgmt. at 294-295; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, Hastings Ctr. Rep., May-June 1993, at 32, 38. When depressed, people lose the ability to compare suicide with alternative solutions or with the prospects for a meaningful future. Thus, victims of depression quickly view their problems as unresolvable and are led to thoughts of escape through death. Furthermore, depression exaggerates the tendency to see the world in black and white terms and encourages the adoption of extreme solutions, such as suicide. Thomas J. Marzen *et al., Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 119 (1985); Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 Issues L. & Med. 123, 134 (1994); Osgood, 10 Issues L. & Med. at 428. Such depression is readily treatable, *see, e.g.*, Block & Billings, 154 Archives Internal Med. at 2042; Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 New Eng. J. Med. 1100, 1101 (1991), and the typical primary care physician who heretofore has been ill-equipped to recognize treatable depression among the elderly and the terminally ill is now being trained to offer just such relief, *see, e.g.*, Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 5: Depression in Primary Care* (1993).

The treatment of the pain and depression accompanying terminal illness is an important focus of hospice professionals' work. They also deal, however, with a number of other fears associated with terminal illness in the minds of most Americans.[8] An important component of

[8] At the request of NHO, the Gallup Organization recently surveyed a national sample of Americans on their knowledge and attitudes related to hospice care. One of the questions asked about fears associated with death. While one in seven (14%) mentioned the pain associated with dying, four in ten (40%) said that being a burden to family and friends was their greatest fear. Other fears included lack of control (8%) and losing one's dignity (8%). *The Cutting Edge: Vital Statistics*, Wash. Post, Oct. 8, 1996, at Z5.

a hospice team's role is to help the patient and family understand the progression of the patient's disease, so that changes are not unexpected and plans can be made, increasing the sense of control that is so important to well-being. By training families and other caregivers and supporting them in their care of the patient through respite care and the assistance of volunteers, hospices help to reduce the burden of caring for a dying relative or friend. Through hospice care, families and loved ones may also benefit from interacting with others facing the same predicament. Daryl J. Miller, *Legal Killing: The Imminent Legalization of a Physician's Affirmative Aid-in-Dying*, 34 Santa Clara L. Rev. 663, 703 (1994) (citing Milton D. Heifetz & Charles Mangel, *The Right to Die* 164 (1975)). Counselors may also use this final phase for anticipatory grief work to help prepare for the sense of loss that accompanies the death of a loved one. *Id.*; Elliott J. Rosen, *Families Facing Death: Family Dynamics of Terminal Illness* 97 (1990); J. Eugene Knott & Eugenia Wild, *Anticipatory Grief and Reinvestment, in Loss and Anticipatory Grief* 55, 57-59 (Theresa A. Rando ed., 1986). But most importantly, hospices can allow patients and their families to use the process of dying as an opportunity to resolve outstanding issues. There are countless stories of how families have used life's final stage as the chance to complete social roles and responsibilities, to reconcile previously strained relationships, and to deepen intimate relationships even further. *See, e.g.*, Rosen, *supra*, at 96; Ira Byock, *Dying Well: The Prospect for Growth at the End of Life* (forthcoming 1997) (copy lodged with the Clerk of the Court). As one commentator has noted, "Making the patient whole again and bringing families together at the bedside is what hospice does best." Miller, 34 Santa Clara L. Rev. at 703 (citing Jack M. Zimmerman, *Hospice: Complete Care for the Terminally Ill* 45 (1981)).

The real proof of hospice as a preferable option for care of the terminally ill lies in the results. The evidence demonstrates that when terminally-ill persons who re-

quest assistance with suicide are treated for depression and are given proper palliative and supportive care, they tend to change their minds about assisted suicide. David Cundiff, *Euthanasia Is Not the Answer: A Hospice Physician's View* 23-24 (1992); New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 26 (1994); Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 531-532, 537 (1994); Hendin, 10 Issues L. & Med. at 164; Osgood, 10 Issues L. & Med. at 429. When physical and psychological suffering are succesfully addressed, the patient becomes free to pursue the greatest amount of personal fulfillment possible in his or her remaining life.[4]

In this sense, terminally-ill individuals who seek assistance with suicide are not that different from "the depressed twenty-one year old, the romantically devastated twenty-eight year old, [and] the alcoholic forty-year old" whose

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[4] Dr. Herbert Hendin, Executive Director of the American Suicide Foundation, recounts the story of a patient named Tim who was given a 25% chance of survival and who was referred to Dr. Hendin for psychiatric consultation:

> His immediate reaction was a desperate preoccupation with suicide and a wish for support in carrying it out. At first he could not consider how he felt about death and its meaning to him but remained preoccupied with concerns about being dependent and unwilling to tolerate the symptoms of his disease or the side effects of proposed treatment. Once we could talk about the possibility or likelihood of his dying * * *, his desperate avoidance subsided. He decided to undergo medical treatment, complained relatively little about the unpleasant side effects, and used the remaining months of his life to connect with his wife and parents in ways that were moving and meaningful for him. Two days before he died, Tim talked of what he would have missed without the opportunity for a loving parting.

Hendin, 10 Issues L. & Med. at 128. Similar stories are recounted elsewhere. *See, e.g.*, Marzen, 24 Duquesne. L. Rev. at 132-133; Byock, 12 Clin. Geriatric Med. at 245-246; Byock, *Dying Well*, *supra*.

suicides the Ninth Circuit acknowledged would be senseless. No 96-110 Pet. App. A-74 (internal quotation marks omitted). As that court conceded, "the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated." *Id.* at A-73. Thus, according to the Ninth Circuit's own logic, the fact that the factors that cause the terminally ill to consider seeking assistance with suicide, such as pain and depression, can be treated is enough to justify the State's prohibition of it. In the vast majority of cases, overturning the state bans on assisted suicide in the name of personal dignity or autonomy, simply because certain people want it, is no more defensible than permitting the depressed twenty-one year old, the romantically devastated twenty-eight year old, and the alcoholic forty-year old to commit suicide. The fact that some people may truly want physicians to help them kill themselves is beside the point. As one commentator noted, "The acceptance of euthanasia for psychiatric patients who are suicidal is simply bad psychiatry. * * * Seriously suicidal patients want suicide. In a society that makes euthanasia accessible for them they will be harder to treat, not easier." Hendin, 10 Issues L. & Med. at 164.

Had the Courts of Appeals understood that "[t]he hospice way of dying * * * offers a middle path between two undesirable approaches in caring for the terminally-ill patient—curative, high-technology medicine on one hand, and death by euthanasia on the other hand," Courtney S. Campbell *et al.*, *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Ctr. Rep., May-June 1995, at 36, 37, they never would have felt constrained by the false dichotomy represented by those two options. Hospice offers patients and their families the opportunity to deal with the pain, depression, and other experiences caused

by dying and—unlike the alternative of physician-assisted suicide—gives them the opportunity to continue to live.[8] In light of the availability of hospice care as a means to alleviate the physical and psychological suffering that underlies terminally-ill patients' desire for assistance with suicide and the potential benefits to the patients' families, the States of Washington and New York were more than justified in concluding that their interest in preserving life was just as strong during the last stage of life as it was during all of life's other stages.

II. STATES ARE JUSTIFIED IN DISTINGUISHING BETWEEN ASSISTED SUICIDE AND THE WITHDRAWAL OF LIFE-PROLONGING TREATMENT.

The courts below also erred in challenging the legitimacy of the historical distinction between assistance with suicide and the withdrawal of life-prolonging treatment or nourishment. *See* No. 95-1858 Pet. App. 29a-34a; No. 96-110 Pet. App. A-76 to A-82. In discarding this distinction, the courts below overlooked the legal basis and the practical benefits of this doctrinal line. Moreover, the line that the courts below adopted in place of this distinction—the distinction between terminally ill and non-terminally ill individuals—is fraught with serious practical problems. This Court should adhere to its prior practice of refusing to extend constitutional rights when such an extension would prove unworkable, *see, e.g.*, *United States* v. *Dixon*, 509 U.S. 688, 711 (1993), and reverse the decisions below.

A. Determining How Long a Terminally-Ill Patient Has to Live Is Notoriously Difficult.

The Ninth Circuit's decision hinged on its conclusion that the State's interests in prohibiting assistance with

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[8] As one hospice patient exclaimed, "I went to the hospital to be cured, and almost died. Then I went into Hospice to die, and lived." *See* Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 Ohio N.U. L. Rev. 755, 758 (1994).

suicide diminished during "the final stages of an incurable and painful degenerative disease," No. 96-110 Pet. App. A-74, when a patient's "death is imminent," *id.* at A-89.[6] Similarly, the Second Circuit ruled that it was "during the final stages of a terminal illness" when death is "imminent and inevitable" that the State's interest in preserving life abated. No. 95-1858 Pet. App. 31a.[7] Although the Ninth Circuit "acknowledge[d] that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence," No. 96-110 Pet. App. A-83, the courts below each expressed their confidence in the medical profession's ability to define terminal illness in such a way that would adequately protect patients from the ill effects resulting from errors in medical and legal judgment. *See id.* at A-83, A-103 to A-104; No. 95-1858 Pet. App. 34a.

Medical research, however, has demonstrated the difficulties that surround any determination of how long a terminally-ill patient has to live.[8] As medical researchers have noted, "physicians typically make poor judgments about survival in terminally ill patients." Nicholas A.

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[6] As the Ninth Circuit reasoned, it is only during the final stage of life when patients are "no longer able to pursue liberty or happiness," No. 96-110 Pet. App. A-72, and "can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends," *id.* at A-74, that the State's interests in preserving life and preventing suicide recede.

[7] *See also* No. 95-1858 Pet. App. 34a (noting that "[t]he plaintiffs seek to hasten death only where a patient is in the 'final stages' of a 'terminal illness' ").

[8] These problems are compounded by the fact that the legal and medical definitions of the term "terminal illness" vary widely depending on the situation, ranging from a diagnosis of a life-threatening or fatal disease to a prognosis of months or weeks to live. The Medicare statute provides that "[a]n individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. § 1395x(dd)(3)(A).

Christakis & José J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs,* 335 New Eng. J. Med. 172, 176 (1996); *see also* Robert A. Pearlman, *Inaccurate Predictions of Life Expectancy: Dilemmas and Opportunities,* 148 Archives Internal Med. 2537, 2537 & nn.2-6 (1988); Howard Brody & Joanne Lynn, *The Physician's Responsibility Under the New Medicare Reimbursement for Hospice Care,* 310 New Eng. J. Med. 920, 921 & nn.3-5 (1984); John F. Potter, *A Challenge for the Hospice Movement,* 302 New Eng. J. Med. 53 (1980). Specifically, assessments of a patient's chances for survival are often biased by the attending physician's recent experiences, which can often lead the physician to overestimate or underestimate the importance of a particular variable. Joanne Lynn *et al., Accurate Prognostications of Death: Opportunities and Challenges for Clinicians,* 163 West J. Med. 250, 251 (1995).

Moreover, the tools of medical prognosis still have yet to account for variations in treatment in an adequate manner. This is particularly problematic because the manner in which the estimate of prognosis necessarily affects treatment options creates a feedback effect that in turn may influence the estimate itself. *Id.* at 256. Such problems are only likely to increase as medical technology continues to improve. Potter, 302 New Eng. J. Med. at 53. Finally, the need for accuracy in such a determination necessarily varies according to the implications surrounding a particular prognosis. Pearlman, 148 Archives Internal Med. at 2537-38. In light of the indeterminacy surrounding the decision as to who is and who is not in the final stages of a terminal illness, the confidence of the courts below in the ability of physicians to apply adequate definitions of terminal illness seems unwarranted.[9]

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[9] In light of these problems, the Ninth Circuit's statement that "should an error actually occur it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most

This Court should avoid the practical difficulties surrounding the definition of terminal illness and should instead base its legal principles on the well-established distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The legal support for the right to refuse life-prolonging treatment has been derived by some courts from the right to privacy (the right to be left alone).[10] Others have based this right on liberty interests (freedom from unwarranted state intrusions into bodily integrity). As this Court observed in *Cruzan*, "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from [this Court's] prior decisions."[11] Indeed, "freedom from unwanted medical attention is unquestionably among those principles 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'"[12]

A right to refuse unwarranted invasions of bodily integrity, however, is different from a right to the assistance of a physician in taking one's own life. The first involves protecting oneself against unwanted medical treatment; the second involves enlisting the aid of practitioners to

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desirable" seems puzzling. No. 96-110 Pet. App. A-83. How an erroneous determination of terminal illness that wrongly encourages a patient to seek assistance with suicide inures to the benefit of the patient is far from clear.

[10] *Cruzan ex rel. Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990) (citing *Schloendorff* v. *Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body * * * .")).

[11] 497 U.S. at 278; *see also id.* at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment").

[12] *Id.* at 305 (Brennan, J., dissenting) (quoting *Snyder* v. *Massachusetts*, 291 U.S. 97, 105 (1934)).

carry out acts inimical to the physician's purpose and creed. The legal and ethical differences between the two are manifest.

B. Empowering Physicians to End Life Would Irrevocably Change the Way Care Is Perceived and Undermine Hospice Care as a More Appropriate Option for Care of the Terminally Ill.

Ironically, the attempt by the courts below to show sympathy for terminally-ill patients threatens to undercut the ability of hospice care to relieve these patients' suffering. As noted earlier, the medical community has only recently begun to appreciate fully the importance of treating physical and emotional pain and other symptoms aggressively and of providing comprehensive palliative care when cure is not possible. The legalization of assisted suicide would divert attention and support away from these important efforts. *See* Chopko & Moses, 70 Notre Dame L. Rev. at 532; Miller, 34 Santa Clara L. Rev. at 704.

An increased focus on assisted suicide as an option would also impede the growing public awareness of the benefits of hospice care. A recent Gallup poll indicated that fully 82% of adults have heard of hospice care, and 88% would choose hospice-style care if they were terminally ill and had less than six months to live. More importantly, the public, when made aware of the kinds of services provided by hospices, prefers hospice care to assisted suicide. The fact that more people indicated a preference for hospice care in this poll, in which the context suggested hospice as an alternative to suicide, than did so in previous surveys that did not mention hospice care as an option further underscores the influence that ignorance about alternatives to assisted suicide has on public attitudes about care for the terminally ill. *See* Judy Foreman, *70% Would Pick Hospice, Poll Finds*, Boston Globe, Oct. 4, 1996, at A3.

The acceptance of assisted suicide as a way to deal with terminal illness would undercut further efforts to increase the public's awareness of hospice as a life-affirming option.[13] States are justified in prohibiting assisted suicide if for no reason other than to avoid the tragedy of having a terminally-ill patient opt for assisted suicide simply out of ignorance about the alternatives.

Finally, the establishment of a constitutional right to assisted suicide would irrevocably distort the picture of end-of-life care so carefully painted by hospices over the last twenty years. If assistance with suicide gains acceptance, some patients may seek such assistance from hospices, forcing hospices to choose between violating their commitment not to abandon any terminally-ill patient and their commitment neither to hasten nor to prolong death. Worse yet, acceptance of assisted suicide might well lead other patients to reject hospice care for fear that such assistance would be urged upon them.[14]

The courts below clearly erred in equating physician-assisted suicide with the withdrawal of life-sustaining treatment and the relief of pain. It would be tragic if the population at large were similarly confused. Hospices regularly comply with patients' requests to withhold or

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[13] The Netherlands has already witnessed the debilitating effect that tolerance of assisted suicide can have on the hospice movement. Miller, 34 Santa Clara L. Rev. at 663 n.270 (attributing the scarcity of hospices in the Netherlands to "the fact that accepting active euthanasia decreases the incentive to create hospices"); *see also* Wheeler, 20 Ohio N.U. L. Rev. at 760.

[14] People growing older have almost instinctively honed in on the ways that assisted suicide might undermine the care that otherwise would be available to them. A recent survey shows that elderly persons reject physician-assisted suicide, indicating that it is the people most vulnerable to the misuse of physician-assisted suicide who are most strongly opposed to it. Harold G. Koenig *et al.*, *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives Internal Med. 2240, 2248 (1996).

withdraw artificial nutrition and hydration. Hospice physicians also regularly order medications to relieve pain, even when an unintended consequence might be the shortening of a terminally-ill patient's life. As Judge Kleinfeld noted, in labeling the Ninth Circuit's proposition "exactly wrong," "[k]nowledge of an undesired consequence does not imply that the actor intends that consequence." No. 96-110 Pet. App. A-162, A-163 (Kleinfeld, J., dissenting). It is important to hospices that people who approach them during the most difficult times of their lives have no doubt about the intent of the care given them.

Dame Cicely Saunders is the physician who is generally credited with founding the first modern-day hospice, London's St. Christopher's, in 1968. Thousands of hospice professionals and volunteers around the world have repeated her promise to patients: "You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." *See* Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* 107 (rev. ed. 1992). The National Hospice Organization asks only that this Court continue to value the lives of terminally-ill patients and that this Court recognize the legitimate interests of States in protecting those lives.

CONCLUSION

For the foregoing reasons, and for those set forth in the petitioners' briefs, the judgments below should be reversed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON,

Petitioner,

vs.

HAROLD GLUCKSBERG, M.D.,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE AMERICAN SUICIDE FOUNDATION, *AMICUS CURIAE*, SUPPORTING REVERSAL

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IN THE

Supreme Court of the United States

October Term, 1996

No. 96-110

STATE OF WASHINGTON,

Petitioner,

v.

HAROLD GLUCKSBERG,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE AMERICAN SUICIDE FOUNDATION, AMICUS CURIAE, SUPPORTING REVERSAL

This brief is in support of reversal and is filed pursuant to Rule 37.3 with the consent of all parties.

Interest of *Amicus Curiae*

The American Suicide Foundation (ASF) is a nonprofit organization dedicated to the prevention and study of suicide. ASF was founded in 1987 by mental health professionals, business and community leaders, and people who had lost loved ones to suicide. Its activities include educational efforts for health professionals and the public on the recognition and treatment of depressed and suicidal individuals, a program of individual grants and postdoctoral fellowships to attract talented scientists into the field, and an institutional grant program to help major medical centers — such as Harvard Medical School, Columbia University College of Physicians & Surgeons, University of Pittsburgh Medical School, Emory University School of Medicine, and University of Texas Medical School — become important centers

for suicide research and treatment. The ASF's Scientific Advisory Committee is comprised of the leading experts on suicide in the country. Its Executive Director, Herbert Hendin, M.D., is an authority on the psychiatric and social aspects of suicide.

ASF has embraced the mission to improve care for people who are terminally or chronically ill, for without good care they are particularly vulnerable to suicide. ASF opposes the legalization of physician-assisted suicide which would not improve the care of seriously ill patients, but rather foster suicides that are preventable.

The decision below of the Ninth Circuit, *Compassion in Dying* v. *Washington*, 79 F.3d 790 (9th Cir 1996) if affirmed, would thoroughly vitiate ASF's efforts.[1] In order to preserve a legal environment in which it will be able to advance the interests of terminally and chronically ill patients in general and those of suicidal patients in particular, ASF respectfully urges the Court to reverse the decisions below.

Summary of Argument

The court gives constitutional significance to the judgment that a terminally ill person's wish to commit suicide is presumptively the autonomous expression of an informed and deliberate assessment of the value of his or her own life, but that a physically healthy person's wish to commit suicide need not be so regarded.[2]

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[1] ASF would be no less adversely affected by an affirmance in the case from the Second Circuit (No. 95-1858), *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), that is being considered in tandem with the instant case, and urges that it also be reversed. Although both decisions make the same erroneous psychosocial assumptions, they appear more explicitly in the Ninth Circuit's decision.

[2] The above distinction was drawn by the court in the context of its effort to rely on the *dictum* in *Planned Parenthood of Southeastern Pa.* v. *Casey* 505 U.S. 833, 851 (1992), but limit its reach, 79 F.3d at 820-821, a goal which the prior panel majority considered logically impossible, 49 F.3d at 590-591.

No sound scientific or clinical basis exists for distinguishing suicidal patients with terminal conditions from other suicidal patients; treatable, reversibie mental disorders, usually of a depressive nature, characterize both. Both groups are ambivalent about the desire to die; both suffer from extreme anxiety and cognitive impairments; both have excessive needs for control, most dramatically expressed by controlling the time and place of their death. In both groups depression interferes with their decision-making ability.

The court is also incorrect in its assertion that "terminally ill adults who wish to die can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family and friends." 79 F.3d at 821. The clinical literature documents that terminally ill persons, including those who have expressed the desire to die, are usually able to spend their last days in meaningful and pleasurable interchange with family and friends.

Moreover, although adults with terminal illness who seek lethal drugs from their physicians are as a group characterized by treatable, reversible mental illness, the same is not true of patients with terminal illness who decide to forgo medical procedures near the end of life. In other words, there is a clinical difference which parallels the ethical distinction between these two types of patient-care situations, a clinical difference which the court ignored as it rejected the ethical distinction. 79 F.3d at 829, n.102.

The court's opinion also rests on erroneous presumptions regarding the ability of the medical profession and the law to limit the exercise of this new-found constitutional right only to those patients who are terminally ill, of sound mind, free of depression or other psychological illness, and unswayed by duress or other undue influence. 79 F.3d at 826-827, 833. These criteria presume the ability on the part of the physician to make the necessary assessments on an objective basis. However, case studies from the United States and the Netherlands demonstrate that a physician's willingness to assist in suicide is itself a powerful influence on the decision of a patient with suicidal tendencies, and that such

physicians are not capable of making an objective assessment of the impact their attitude has had upon the patient.

In the Netherlands, despite legal and professional guidelines designed to ensure that assisted suicide and euthanasia takes place only upon the decision of a competent patient free of duress, the attitudes and decisions of physicians—particularly in presenting euthanasia as a reasonable option to patients—play a decisive role. The Dutch experience demonstrates that physicians are ill-suited, in an environment tolerant of assisted suicide and euthanasia, to keep such practices within prescribed limits. The Dutch experience also demonstrates the futility of reliance on legal regulations to maintain such limits. The guidelines established by Dutch courts have not been followed; the practice of euthanasia has moved from the terminally ill to the chronically ill, from cases of untreatable physical illness to cases of treatable psychological distress, and from voluntary euthanasia to involuntary euthanasia. Indeed, the majority of cases in which doctors actively cause or hasten death occur without the patient's explicit request. Legalization of assisted suicide and euthanasia has also impaired the treatment of depressed suicidal patients by making the distress of such patients a legitimate reason for their dying.

That this should occur in a nation with a strong tradition of adherence to rules, and in a medical profession of great technical competence and noted dedication to individual patients, demonstrates the corrosive effects of removing the barriers against physician participation in killing. Depriving the states of the power to prevent physician-assisted suicide among terminally ill patients will deprive them of the ability to afford those patients the protection and help that are afforded suicidal patients who are not terminally ill.

ARGUMENT

I. THE DECISION BELOW ERRS IN ASSUMING THERE EXISTS A SOUND SCIENTIFIC OR CLINICAL BASIS FOR DISTINGUISHING SUICIDAL PATIENTS WITH TERMINAL CONDITIONS FROM SUICIDAL PATIENTS WITHOUT TERMINAL CONDITIONS; TREATABLE, REVERSIBLE MENTAL DISORDERS CHARACTERIZE BOTH.

In 25 percent of all suicides, problems derived from a physical illness play an important role.[3] The percentage for whom illness is important increases with age, rising from 13 percent in those under 39 when they kill themselves to 70 percent in those over 60.[4] However, like other suicidal individuals, patients who wish to kill themselves during a serious illness are characteristically suffering from a treatable mental illness, most commonly a depressive condition.[5] A comprehensive 1995 review of decades of studies on suicide and physical illness concludes, "there is little evidence to support the notion that chronic or terminal illness is an independent risk factor for suicide, outside the context of depression or other mental disorder.[6] Although physical pain or social isolation, including lack of family support, contribute to the wish for death, none is as significant as depression, which researchers have found to be the only predictor

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[3] T.B. Mackenzie & M.K. Popkin, *Medical Illness and Suicide, in Suicide Over the Life Cycle* (S.J. Blumenthal & D.J. Kupfer eds., 1990).

[4] Id.

[5] J.H. Brown et al., *Is it Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psychiatry 208 (1986); H.M. Chochinov et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185 (1995); D.C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities*, 2 Issues in Law & Med 147, 160 (1993).

[6] E.R. Mościcki, *North American Perspectives: Epidemiology of Suicide, in Suicide and Aging: International Perspectives* 137 (J.L. Rearson & Y. Conwell eds., 1995).

of the desire for death even given the presence of these other factors.[7]

Strikingly, the overwhelming majority of the patients who are terminally ill do not attempt or commit suicide.[8] Some may voice suicidal thoughts in response to transient depression or severe pain, but these patients usually respond well to treatment for depressive illness and pain medication, and are grateful to be alive.[9]

Depression and the other mental disorders motivating suicidal impulses and acts are treatable and reversible, and when these mental illnesses are addressed with sensitivity and clinical expertise, the thoughts of suicide ordinarily subside.[10] Unfortunately, depression is also underdiagnosed and often inadequately treated. Even though most people who kill themselves are under medical care at the time of death, their physicians often fail to recognize the symptoms of depressive illness or even if they do, to give inadequate treatment.[11]

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[7] E.J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 The Lancet 1805 (1996); H. Hendin & G.L. Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am J. Psychiatry 143 (1993).

[8] E. Robins et al., *Some Clinical Considerations in the Prevention of Suicide Based on a Study of 134 Successful Suicides*, 49 Am J. Pub. Health 888 (1959); C.P. Seager & R.S. Flood, *Suicide in Bristol*, 11 Br. J. Psychiatry 919 (1965).

[9] Hendin & Klerman, *supra* note 7 at 143-145; Clark, *supra* note 5 at 160-161.

[10] NIH Consensus Development Panel on Depression in Late Life, *Diagnosis and Treatment of Depression in Late Life*, 268 JAMA 1018, 1024 (1992); New York State Task Force on Life and the Law, *When Death is Sought*, 175-177 (1994); A.J. Roth & J.C. Holland, *Treatment of Depression*, 14 Primary Care in Cancer 24 (1994).

[11] NIH Consensus Development Panel on Depression in Late Life, *supra* note 10 at 1021-22.

People are apt to assume that seriously or terminally ill patients who wish to end their lives are different from those who are otherwise suicidal. But an early reaction of some patients to the knowledge of serious illness and possible death, is terror, depression and a wish to die. Such patients are not different from patients who react to other crises in their lives by a desire to end the crisis by ending their lives.[12]

Although the fear of death itself is not usually given by patients as a reason for requesting assisted-suicide, clinicians treating such patients find that many displace anxieties about death onto the circumstances of dying — loss of dignity, pain, being dependent on others, or the unpleasant side effects resulting from medical treatments. Focusing on, or becoming enraged at, the process distracts from the fear of death itself.[13]

For example, Tim, a young professional in his early thirties who had acute myelocytic leukemia, was referred for psychiatric consultation.[14] With medical treatment, Tim was given a 25 percent chance of survival; without it, he was told, he would die in a few months. An ambitious executive whose focus on career success had led him to neglect his relationships with his wife and family, Tim was stunned. His immediate reaction was a desperate, angry preoccupation with suicide and a request for support in carrying it out. He was worried about becoming dependent and feared both the symptoms of his disease and the side effects of treatment. Tim's anxieties about the painful circumstances that would surround his death were understandable, but all his fears about dying amplified them. Once Tim could talk about the possibility or likelihood of his dying — what separation from his family and the destruction of his body meant to him — his desperation subsided. He used the remaining months of his life to

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[12] Hendin & Klerman, *supra* note 7 at 143-145.

[13] H. Hendin, *Assisted Suicide, Euthanasia, and Suicide Prevention: The Implications of the Dutch Experience*, 25 Suicide and Life-Threatening Behavior 193 (1995).

[14] *Id.*

become closer to his wife and parents. Two days before he died, Tim talked about what he would have missed without the opportunity for a loving parting.

Like Tim, the vast majority of those who request assisted suicide or euthanasia are motivated primarily by dread of what will happen to them rather than by current pain or suffering.[15] Patients do not know what to expect and cannot foresee how their conditions will unfold as they decline into death. Facing this ignorance, they fill the vacuum with their fantasies and fears. When these fears are dealt with by a caring sensitive physician, the request for death usually disappears.

Along with these disorders of depression and anxiety, suicidal patients, regardless of their physical condition, are prone to impose conditions on life: I won't live ... "without my husband," or "if I lose my looks, power, prestige or health," or "*if I am going to die soon.*" They are afflicted by the need to make demands on life that cannot be fulfilled. Determining the time, place, and circumstances of their death is the most dramatic expression of their need for control.[16]

This rigidity reflects the impaired thought processes and irrationality that characterize the depressed state of those who are suicidal whether they are terminally ill or not. Cognitive functioning is impaired by unrealistically low self-regard, ideas of deprivation and rejection often in the face of overt demonstrations of affection, and a tendency toward self-blame with no logical basis.[17]

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[15] P. Admiraal, *A Physician's Responsibility to Help a Patient Die, in The Good of the Patient: The Good of Society*, (1992).

[16] Hendin, *supra* note 13 at 193.

[17] A. Beck, *Thinking and Depression, in Arch. Gen. Psychiatry* 324 (1963); D.C. Clark et al., *Intellectual Functioning and Abstraction Ability in Major Affective Disorders* 26 (1985); L. Ganzini et al., *Depression, Suicide, and the Right to Refuse Life-Sustaining Treatment*, 4 J. Clinical Ethics 337, 338 (1995).

One particular cognitive impairment typically found in depressed suicidal patients is the tendency to develop a distorted and overly negative perception of their physical condition, while remaining unaware of their depression. This lost understanding can sometimes become so intense as to lead to an erroneous belief that they are ill and dying, when in fact they are not. For example, in two separate community-based studies of elderly persons who died by suicide, there were more persons who killed themselves because they mistakenly believed they had cancer, than there were persons who died with cancer or any other terminal illness.[18]

Statements such as "I don't want to be a burden to my family" or "My family would be better off without me" are also often made by those requesting assisted suicide or euthanasia. Such expressions reflect depressed feelings of worthlessness or guilt and may be a plea for reassurance. However, such statements are also classic indicators of suicidal depression in patients who are in good physical health. Whether healthy or terminally ill, these patients need assurance that they are still wanted; they also need treatment for their depression.[19]

Another characteristic of suicidal patients, regardless of their state of physical health, is a sometimes calm demeanor that masks their depressed and anxious mental state.[20] In particular, some patients who are depressed and suicidal appear less depressed and calm after resolving to end their lives. It is coping with the circumstances of life that agitates and depresses these patients; that they find relief in the decision to die is hardly an indication that the decision is appropriate.

The ambivalent and variable nature of the wish to die also characterizes both suicidal patients who are terminally ill and

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[18] Y. Conwell et al., *Suicide and Cancer in Late Life*, 41 Hosp. & Community Psychiatry 1334, 1337-38 (1990); G.K. Murphy, *Cancer and the Coroner*, 237 JAMA 786, 788 (1977).

[19] Hendin, *Suicide and the Request for Assisted Suicide: Meaning and Motivation*, 35 Duquesne L.Rev. 285 (1996).

[20] Clark, *supra* note 5 at 155-56.

suicidal patients who are not terminally ill.[21] For example, in one study of patients with terminal illness, interviews were conducted two weeks after they had expressed the wish to commit suicide, and already two-thirds showed a significant decrease in the extent of the desire to die.[22] If the doctor fails to recognize the ambivalence that underlies the patient's request for death, the patient may become trapped by that request and die in a state of unrecognized terror.[23]

An assisted-suicide case that Compassion in Dying, a corporate plaintiff in the district court below, 79 F.3d at 794, n.2, regards as a model, was the subject of a cover story in the *New York Times Magazine* in 1993. The case captures the coercive effect on an individual, made vulnerable by her physical and mental condition, of being surrounded by those who did not understand, or choose to hear, her ambivalence.[24]

The story describes the suicide of Louise, a Seattle woman whose death was arranged by her doctor and the Reverend Ralph Mero, the head of Compassion in Dying. Louise expresses conflicting wishes — to live and to die — but only for death does she find support. Those around Louise became part of a network

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[21] Chochinov et al., *Desire for Death in the Terminally Ill*, *supra* note 5 at 1185-1191.; Jensen and Petty, *The Fantasy of Being Rescued*, 27 Psychoanalytic Q. 327 (1958); H. Hendin, *Suicide in America* 2d Ed. (1995).

[22] Chochinov et al., *supra* note 5 at 1185-1191.

[23] H. Hendin, *Selling Death and Dignity*, 25 Hastings Center Report 19 (1995). This characteristic ambivalence has been studied in those rare cases of survival following suicidal jumps from high bridges. According to one jumper who survived a leap from the Golden Gate Bridge, "From the instant I saw my hand leave the railing, I knew I wanted to live. I was terrified out of my skull." After waking up in the water he remembered, "I was screaming, 'Oh, God, save me! Oh, God, I want to live.'" Leo Rangell, *The Decision to Terminate One's Life: Psychoanalytic Thoughts on Suicide*, 18 Suicide and Life-Threatening Behavior 28, 30-31 (1988).

[24] L. Belkin, *There's No Simple Suicide*, N. Y. Times Mag. November 14, 1993, at 50.

pressuring her to stick to her decision and to carry it out in a timely manner. Louise is shown to be clearly frustrated by not having someone to talk to who had no stake in persuading her to stick to her initial decision. For example, at one point Louise, now looking terrified, tells her mother "I just feel as if everyone is ganging up on me, pressuring me. I just want some time." Individually and collectively, those involved engender a terror in Louise that she bears alone, while they reassure each other that they are sensitively engaged in gratifying her last wishes. The end of her life does not seem like death with dignity, nor is there much compassion in the way Louise was helped to die.[25]

Finally, it must be underscored that the specific desire to be put to death by one's doctor can be found in suicidal patients both with and without terminal illness.[26] Therapists who are unaware of this assume that patients who have sought their help will see them as saviors, when actually they have been cast in the role of executioner, with the patient typically fantasizing closeness or union with the doctor through death.[27]

The prominent assisted-suicide case involving the internist Timothy Quill, a plaintiff in *Quill v. Vacco*, and his patient, Diane, illustrates the hazards of physicians offering lethal drugs to suicidal patients with serious physical illness, rather than the treatments and interventions ordinarily indicated for suicidal patients.[28] The case involved oversights regarding the indicators of Diane's depression, shared reunion fantasies, and the physician's apparently one-sided encouragement of his vulnerable

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[25] Hendin, *supra* note 23 at 21.

[26] S. Asch, *Suicide and the Hidden Executioner*, Int'l Rev. Psychoanalysis 51 (1980); H. Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* (1996).

[27] H. Hendin, *Psychodynamics of Suicide With Particular Reference to the Young*, 148 Am. J. Psychiatry 1150 (1991).

[28] T. E. Quill, *Death and Dignity - A Case of Individualized Decision Making*, 324 N. Eng. J. Med. 691 (1991); T.E. Quill, *Death and Dignity: Making Choices and Taking Charge* (1993).

patient's suicidal urges, both by what he said, and by what he failed to say and do.

Diane, who suffered from depression and alcoholism through much of her adult life, developed acute leukemia. She reacted with rage and despair, which shortly turned to thoughts of suicide. Quill notes that he responded to her emotional turmoil, as well as to her decision to refuse chemotherapy (with a 25% chance of success), made shortly after the diagnosis, by joining together with her to lament "her tragedy and the unfairness of life." When Diane asks for his help in committing suicide, after justifying it by her need to be in control and by her conviction that she would die during treatment for leukemia, Quill never questions her insistence on total control, an impossible demand in the face of serious illness, or sees this as potentially an aspect of depression, not simply a reasonable response. Moreover, he does not challenge her firm insistence that treatment would fail, which she had no way of knowing.

Although initially Quill tells Diane that he cannot take part in her suicide, he appears to have conveyed to her just what he later communicated to the general public: that her "request made perfect sense" to him. Quill ultimately responds to Diane's suicidal wishes by referring her to the Hemlock Society, which he describes to her as "helpful," and eventually by prescribing for her the barbiturates that the Society recommended she use. When Diane says goodbye to Quill, shortly before her death, she promises "a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons shining in the sunset." Quill concluded his account of the case in the *New England Journal of Medicine* by wondering whether he "will see Diane again, on the shore of Lake Geneva at sunset, with dragons swimming on the horizon."[29]

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[29] Analysis of this case is taken from H. Hendin, *supra* note 26 at 125-128. See also P. Wesley, *Dying Safely*, 8 Issues in Law and Med. 467 (1993).

II. ALTHOUGH PATIENTS WITH TERMINAL ILLNESS WHO SEEK LETHAL DRUGS FROM THEIR PHYSICIANS ARE VIRTUALLY CERTAIN TO HAVE TREATABLE, REVERSIBLE MENTAL ILLNESS, THE SAME IS NOT TRUE OF PATIENTS WITH TERMINAL ILLNESS WHO DECIDE TO FORGO MEDICAL PROCEDURES NEAR THE END OF LIFE.

The Ninth Circuit found the state's interest in physician-assisted suicide to be no different from its interest in a patient's refusal of treatment. 80 F.3d at 828, 837. The merits of any ethical distinction will be argued in other briefs, but the clinical evidence provides a basis for distinguishing the two situations. Mental competence distinguishes the two groups, as research is beginning to demonstrate.[30] This is not to say that some people who refuse treatment are not suicidally depressed, but that suicidal depression is not characteristic of the group.

This research is confirming years of clinical impressions that neither mental impairment nor preoccupation with suicide is characteristic of the choice by seriously ill patients to forgo treatments of uncertain effectiveness that are nonetheless likely to cause intense burdens, such as pain, bodily invasion, and the emotional suffering that can accompany physical isolation during a course of treatment in a hospital, as opposed to being at home with loved ones.[31] Under these circumstances, the choice to forgo medical interventions is not suicide, but a judgment about how to live before one dies.

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[30] L. Ganzini et al., *supra* note 17 at 338-339.; M. Lee & L. Ganzini, *Depression in the Elderly: Effect on Patient Attitudes Toward Life-Sustaining Therapy*, 40 J. Am. Geriatrics Soc'y 983 (1992); L. Ganzini et al., The Effect of Depression Treatment on Elderly Patients' Decisions Regarding Life-Sustaining Medical Treatment (unpublished paper).

[31] *See*, for example, C.M. Saunders, *The Last States of Life, in Hospice Care: Principles and Practice* 5-11 (C.A. Corr & D.M. Corr eds., 1983); Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* (1992); Kenneth P. Cohen, *Hospice: Prescription for Terminal Care* (1979).

The lower court's position is linked to its failure to recognize that, legally and medically, the right to forgo treatment is rooted in our abhorrence of the violence inherent in forcing medical interventions on unwilling, competent adults, regardless of their physical condition, not in social acceptance of suicide or indifference to the suicidal acts of the physically ill. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, at 277, 280 (1990). The strength of the competent patient's right to refuse unwanted treatment is not a function of physical condition. Under principles of informed consent, competent adult patients, whether or not they are terminally ill, can refuse any treatment for any reason.[32]

III. AS ILLUSTRATED BY THE EXPERIENCE OF THE NETHERLANDS, PHYSICIANS CANNOT BE RELIED UPON TO IDENTIFY THOSE PATIENTS WHO WOULD BE CONSTITUTIONALLY ENTITLED TO ASSISTANCE IN KILLING THEMSELVES, AND TO DISTINGUISH THEM FROM PATIENTS WHO WOULD NOT HAVE THE RIGHT TO SUCH ASSISTANCE.

A. The Decision Below Relies Upon the Ability of Physicians to Make Objective Assessments Regarding the Nature of a Patient's Desire for Death that Physicians Willing to Cooperate in Assisted Suicide Are Not in a Position to Make.

The Ninth Circuit stated that decisions by terminally ill patients to end their lives do not really constitute suicide, nor is helping them to do so "assisted suicide." 79 F.3d at 802, n.5, 824. So long as the patient is of sound mind, free of depression or other psychological illness, and unswayed by duress or other

[32] G.A. Annas, *The 'Right to Die' in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 Duquesne L.Rev. 875, 876-77 (1996). That right may be limited under certain circumstances, such as the presence of a contagious disease like tuberculosis. *See also* A.M. Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 4 Ariz. St. L. J. 647, 656-58 (1984).

undue influence, *id.* at 826-827, 833, the court holds that he or she is merely exercising a constitutionally recognized "liberty interest in hastening one's own death." *Id.* at 816.[33]

However, as Point I of this brief demonstrates, this paradigm lacks a real world foundation. Individuals with severe illness who wish to kill themselves have the same clinical profile as other suicidal individuals. Both have mental disorders characterized by depression, extreme anxiety, and impaired cognition that render them vulnerable to the coercive influence of others.

There is another problem as well. The decisions and acts that the court's paradigm entails take place in clinical contexts which are subject to infinite variation, and the paradigm supposes that in each case the physician, after whatever consultation he may seek or may be mandated by the State, will be able to make several critical assessments.

In addition to ruling out that the terminally ill patient wishing to kill himself or herself has any mental disorder, the physician must be able to assess objectively the patient's understanding of the physician's role in shaping the patient's decision. A physician's willingness to assist in suicide in a particular case will likely follow from a determination that this is a reasonable course of action for that patient; by communicating this willingness, the physician will likely influence the patient's own determination, particularly if, as is most often the case, the patient has a depressed mental state that the physician simply missed. The physician must be able to make a similar objective assessment regarding the attitude and conduct of family members on the patient's decision.

If any of these assessments are made improperly—if the patient is depressed or if the physician's or family's attitudes have prompted or reinforced the desire for suicide—the patient's

[33] The Second Circuit disagreed with the Ninth Circuit that a "right to die" is an aspect of the liberty which the Due Process Clause protects, 80 F.3d at 723-725, but it came out in precisely the same place by also disagreeing with it over what constitutes "suicide." *Id.* at 729-730.

"choice" is not autonomous and there is no basis for granting constitutional protection to the physician's actions in causing death.

The Ninth's Circuit's confidence in the sound judgment of physicians notwithstanding, there is little reason to trust in the physician's ability to properly evaluate the patient's psychological state and the factors affecting it. The interactions described by Dr. Quill in his own account of the death of Diane (above, pages 11-12) suggest that doctors willing to assist in their patients' deaths become so closely entwined with their patient's decision that they forfeit the professional distance necessary to objectively assess their own potential influence on the patient's decision. The case of Louise (above, pages 10-11) illustrates not only the power of physicians to influence these decisions, but the role that family attitudes may play.

Furthermore, contrary to the Ninth Circuit's assumptions regarding the efficacy of statutory and professional guidelines to ensure the integrity of decisions for assisted suicide, 79 F.3d at 832-833, 837, these decisions and actions will occur in the zone of confidentiality between physicians and patients and as such, will remain largely beyond the reach of such regulation.[34] The experience of the Netherlands, a society with a strong legal tradition and a medical profession of great technical competence and noted dedication to individual patients, provides further proof of this reality.

[34] Daniel Callahan and Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 8-10 (1996).

B. The Experience of the Netherlands Demonstrates the Inability of Physicians, In an Environment Tolerant of Assisted Suicide and Euthanasia, to Make the Objective Assessments Necessary to Keep Such Practices within Prescribed Limits.

The Netherlands has not formally decriminalized assisted suicide or euthanasia.[35] Rather, in a series of court decisions,[36] in guidelines issued by prosecutors and the Royal Dutch Medical Association (KNMG), and recently in statute,[37] the Dutch have fashioned criteria under which doctors will not be subject to punishment for participating in physician-assisted suicide or euthanasia. The criteria reflect the same confidence in the ability of physicians to make the critical assessments and distinctions regarding the eligibility of patients for such measures that animates the decision of the Ninth Circuit.[38]

Three studies of the Dutch experience—by a British attorney and legal historian,[39] an American gerontologist,[40] and an

[35] Killing a person at his "express and serious request" is punished by Article 293 of the Dutch Penal Code; inciting or providing the means for another to commit suicide is prohibited by Article 294. John Keown, *Some Reflections on Euthanasia in the Netherlands, in Euthanasia, Clinical Practice and the Law* 193, 193-194 (Luke Gormally ed., 1994) ("Keown I"). *See also* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope, in Euthanasia Examined* 261 (1995) ("Keown II").

[36] Toleration of euthanasia is based on the principle of *force majeure*, or legal necessity, arising from a "conflict of duties" between the physician's responsibility to the law, which makes euthanasia illegal, and the responsibility to help a patient whose unrelievable suffering makes euthanasia necessary. Keown I, *supra* at 194-198; Carlos Gomez, M.D., *Regulating Death: Euthanasia and the Case of the Netherlands* 38 (1991).

[37] Henk Jochemsen, *Euthanasia in Holland: An Ethical Critique of the New Law*, 20 J. Med. Ethics 212, 214 (1994).

[38] *See* Gomez, *supra* at 21; 79 F.3d at 827.

[39] Keown I and Keown II, *supra.*

[40] Gomez, *supra.*

American psychiatrist[41]—have independently concluded that these guidelines are not only unenforced, but, as is likely to be the case for any proposed regulation of assisted suicide and euthanasia, unenforceable.[42] Most pertinent for purposes of this discussion is how the principle of voluntariness is compromised.

Under the Dutch guidelines, the patient must request euthanasia, and the request must be free and voluntary, informed, and without duress. In practice, however, the physician's role as arbiter of whether a patient's request is truly voluntary influences the decision. These requirements "do not prevent either the doctor or nurse from mentioning euthanasia to the patient as an option or even strongly recommending it."[43] Nor can they ensure that euthanasia is not chosen "out of ignorance or misunderstanding of one's situation."[44] Thus, while "the ideal commands that only patients may choose whether to exit this life via euthanasia, the reality of the practice seems to suggest that only physicians may actually open the door and, in some instances, may describe where the door is to patients who cannot clearly see it."[45]

The Van der Maas Survey—the official study of euthanasia commissioned by the Dutch government—revealed that more than half of Dutch physicians consider it appropriate to introduce the subject of euthanasia to their patients.[46] In a study of euthanasia done in Dutch hospitals, doctors and nurses reported that more requests for euthanasia came from families than from the patients themselves, and the investigators concluded that families, doctors, and nurses were involved in pressuring patients to accept

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[41] Hendin, *supra* note 26.

[42] Gomez, *supra* note 21 at 121-122; Hendin, *supra* note 26 at 220; Keown II at 265-266, 286-287.

[43] Keown I, *supra* at 203.

[44] Gomez, *supra* note 7 at 104.

[45] *Id.* at 109.

[46] P.J. van der Maas, et al., *Euthanasia and other Medical Decisions Concerning the End of Life* 102, Table 9.7 (1992) (hereinafter *Survey*).

euthanasia.[47] These actions are presumably motivated by a feeling that the patient's situation is "hopeless;" however, such pressure effectively tells the patient that his or her life is not worth living, a message that has a powerful effect on a vulnerable patient's outlook and wishes.[48]

In one case, a woman who no longer wanted to care for her chronically-ill husband gave him a choice between euthanasia and admission to a nursing home. The patient, fearful of being cared for by strangers in an unfamiliar environment, chose euthanasia; the doctor, though aware of this coercion, performed it.[49] A leading Dutch practitioner of euthanasia even concedes that being "a nuisance to [one's] relatives," because those relatives want to enjoy the patient's estate, may be an acceptable circumstance for euthanasia.[50]

The 1994 television film, *Death by Request*, documented the euthanasia of a Dutch patient, Cees van Wendel, afflicted with amyotrophic lateral sclerosis (Lou Gehrig's disease). In the film, the patient's wife answers all questions, including those regarding whether her husband wants to die. The doctor at no time asks to speak to Cees alone; neither does he ask if anything would make it easier for him to communicate or if additional help in his care would make him want to live.[51] The film, clearly intended to demonstrate the compassionate aspect of euthanasia, instead illustrates the strong influence that families and physicians may have on the decisions of patients, and the inability of physicians, in an environment where euthanasia is accepted practice, to control for such factors.

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[47] H.W. Hilhorst, *Euthanasie in het Ziekenhuis* [Euthanasia in the Hospital] (1983).

[48] Gomez, *supra* note 7 at 110.

[49] Hendin, *supra* note 14 at 93.

[50] Keown I, *supra* at 203 (interview with Dr. Herbert Cohen).

[51] Hendin, supra at 115.

Similar concerns are raised by the case of Dr. Boudewijn Chabot, the subject of a landmark decision by the Dutch Supreme Court. The pseudonymous victim, Netty, was divorced from an abusive husband and had lost both of her sons, the second two months earlier to cancer. She was referred to Dr. Chabot, a psychiatrist, by a euthanasia society. Dr. Chabot did not treat Netty as a patient, but after a two-month-long period of consultations, decided that her mental state could not improve and prescribed barbiturates for her to kill herself. Several psychiatrists who were consulted by Dr. Chabot (none of whom saw Netty personally) believed that assisting in her suicide was an appropriate course of action.[52] Netty was assisted in suicide by Dr. Chabot four months after the death of her second son.

In these cases, there was no objective assessment of factors influencing the patient's request for euthanasia. Moreover, the attitudes of the physicians clearly demonstrated the inappropriateness of relying upon their judgment to make such assessments. Netty's depression and bereavement, which were clearly the decisive factors in her suicide, were judged "untreatable" by Dr. Chabot after he accepted at face value her refusal of any and all attempts at treatment for depression. Even without treatment, time alone was likely to have affected her mood.

How suitable alternatives are presented to a patient is as important as whether they are presented at all. Cees van Wendel's physician betrayed his own stake in the patient's decision for suicide by the following statement: "[W]hat else can I offer the man? I can give him the finest wheelchair there is, but in the end

[52] The Dutch Supreme Court, which ruled on the Assen case in June 1994, affirmed lower court rulings that mental suffering can be grounds for assisted suicide, but it found Chabot guilty of not having had a psychiatric consultant see the patient. Although the court expressed the belief that such consultation was particularly necessary in the absence of physical illness, since it felt that in all other regards Chabot had behaved responsibly, it recommended no punishment. *Id.* at 64-69.

it is only a stopgap. He's going to die and he knows it."[53] Legal and professional guidelines did nothing to prevent these avoidable suicides.

IV. THE EXPERIENCE OF THE NETHERLANDS FURTHER DEMONSTRATES THE VIRTUAL IMPOSSIBILITY OF REGULATING PHYSICIAN-ASSISTED SUICIDE OR LIMITING IT TO COMPETENT, TERMINALLY ILL INDIVIDUALS.

As the cases previously discussed suggest, the history of euthanasia in the Netherlands is one of constant expansion from allegedly small beginnings. While this history was dismissed by the Ninth Circuit as irrelevant, 79 F.3d at 830, n. 114, the Supreme Court of Canada,[54] the Select Committee on Medical Ethics of the British House of Lords,[55] and the New York State Task Force[56] all considered it relevant to test the presumption that assisted suicide and euthanasia can be effectively limited through legal regulation. As these bodies concluded, the Netherlands experience demonstrates that this presumption is invalid.

A. Virtually Every Guideline Established by the Dutch to Regulate Euthanasia Is Routinely Violated in Practice.

According to guidelines issued by the Dutch minister for health, physicians will not be subject to prosecution under articles 293 and 294 of the Dutch penal code under the following conditions: (1) the request for euthanasia must come only from the patient and must be entirely free and voluntary; (2) the patient's request must be well considered, durable, and persistent; (3) the

[53] *Id.* at 119.

[54] Rodriguez v. Attorney General, 107 D.L.R.4th 347, 402-403 (Can. 1993).

[55] H.L. Rep. of the Select Comm. on Med. Ethics 28-29, 48 (1994).

[56] N.Y. State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 133 (1994).

patient must be experiencing intolerable (not necessarily physical) suffering, with no prospect of improvement; (4) euthanasia must be a last resort, and other alternatives must have been considered and found wanting; (5) euthanasia must be performed by a physician; and (6) the physician must consult with an independent physician colleague who has experience in this field.[57] The guidelines also have required that cases of euthanasia be reflected as such on death certificates, and that all cases of euthanasia be reported to authorities.[58]

In practice, however, most of these guidelines are routinely violated. As discussed previously, the principle of voluntariness is compromised by the mental state that characterizes these patients, and the undue influence of physicians and family members. The criterion of "intolerable suffering" has been stretched, with the approval of the Dutch Supreme Court in the case of Dr. Chabot, to include cases where there is absolutely no physical illness and where the mental suffering itself might well have been treatable. The criterion of terminal illness was abandoned by the Dutch on the ground that cases of chronic illness could involve a situation of "necessity" equal to those of terminal illness. In general, the logic of permitting euthanasia in one set of circumstances inevitably leads to acceptance of euthanasia in other circumstances where the "equities" appear to be similar.[59]

Two guidelines intended to provide an independent "check" upon euthanasia practices are also frequently dishonored. The required consultation with a second physician is often *pro forma* and apparently has taken place without the second doctor

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[57] Keown I, *supra* at 198-201.

[58] Note, *Court of the Hague (Penal Chamber) April 2, 1987*, 3 Issues in Law & Med. 451, 452 (1988); Keown I, *supra* at 198.

[59] Keown I, *supra* at 210-216. "[I]n instances in which the practice of euthanasia seemed to have gone beyond the generally assumed bounds, there was still an appeal to a more liberal interpretation of the criteria or an appeal to the exigencies of the particular case that, according to the narrator, excused him or her from following a particular guideline." Gomez, *supra* note 36 at 97.

personally seeing the patient.[60] The Van der Maas Survey revealed that consultation takes place in less than half of the cases where euthanasia is practiced without the explicit request of the patient,[61] and that a third of physicians do not consider the requirement to be important.[62] In addition, known euthanasia practitioners are likely to be called in to consult in such cases. Participation by such physicians is not likely to result in decisions not to perform euthanasia.[63]

The requirement that euthanasia be accurately reported on death certificates and subject to review by authorities is breached in the vast majority of cases. The Van der Maas Survey showed that 72 percent of deaths where euthanasia was performed in response to an explicit request by the patient were falsely reported as "natural deaths."[64] Virtually all cases where medical decisions to end life were taken *without* explicit request were reported as natural deaths and not reported to authorities.[65] This pattern of non-compliance has many consequences, not the least of which is to undermine the enforceability of any objective set of standards or guidelines:

> Apparently, many euthanasia advocates want to create their own guidelines, which they can do freely if they do not report their cases. The problem, therefore, is not simply a slippery slope on which legalization of euthanasia for one group of patients inevitably leads to legalization for others. Legalization for whatever group

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[60] M.T. Muller et al., *Voluntary Active Euthanasia and Physician-Assisted Suicide in Dutch Nursing Homes: Are the Requirements for Prudent Practice Properly Met?*, 42 J. Am. Geriatrics Soc'y 624, 627 (1994).

[61] *Survey*, *supra* at 64.

[62] *Id.* at 96.

[63] Hendin, *supra* note 26 at 122-124.

[64] *Survey*, *supra* at 49, Table 5.14. Even after explicit statutory protection was given to Dutch physicians who follow the guidelines, 40 percent still reported euthanasia deaths as natural deaths. Hendin at 124.

[65] *Id.* at 65.

> happens to be first on the slope cannot be regulated. Only after guidelines have been stretched, ignored, or circumvented for some time does pressure develop to legalize what is already practiced.[66]

Another consequence is that it allows those who favor euthanasia to pretend that the practice in the Netherlands is well-controlled and not subject to abuse. According to one Dutch medical ethicist, "the majority of cases in which doctors intentionally shorten patients' lives, either by act or omission, remains unnotified, unchecked, and invisible to justice."[67]

B. Legalization of Euthanasia on Request Has Led in the Netherlands to Acceptance of Nonvoluntary Euthanasia.

The Van der Maas Survey reveals that the majority of medical decisions to end life take place without the specific request of the patient. According to the Survey's official summary, slightly under two percent (2300) of all deaths (approximately 130,000) in the Netherlands result from euthanasia administered to a person who has requested it; an additional 400 deaths (0.3 percent) resulted from assisted suicide.[68]

In contrast, many thousands more cases of intentional shortening of life by physicians do not involve an explicit request of the patient. The Survey reports that 1000 deaths (0.8 percent) occur in cases where "physicians prescribe, supply, or administer a drug with the explicit purpose of hastening the end of life without explicit request of the patient."[69] Twenty-seven percent of doctors indicated they had terminated the lives of patients without a request to do so; another 32 percent could conceive of doing so.[70]

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[66] *Id.* at 124.

[67] Henk Jochemsen, *supra* note 37, at 215.

[68] *Survey*, *supra* at 178-179.

[69] *Id.* at 194.

[70] *Survey* at 58, Table 6.1.

According to the Survey other forms of hastening death without the patient's consent are common practice in the Netherlands as well. In over 5,000 of the 49,000 cases in which medical decisions were made at the end of life, the doctors' primary intention in administering pain medication or withdrawing or withholding treatment was to shorten life; in over 11,000 cases this was a secondary goal.[71] In about 25,000 cases decisions were made that might or were intended to end the lives of patients without consulting them.[72] In about 20,000 cases, physicians gave the patient's impaired ability to communicate as their justification for not seeking consent.[73] That left about 5,000 cases in which physicians made decisions that might or were intended to end the lives of competent patients without consulting them.[74]

In 13 percent of cases, physicians who did not communicate with competent patients concerning decisions that might or were intended to end their lives gave as the reason for doing so that they had previously had some discussion of the subject with the patient.[75] Yet it seems incomprehensible that a physician would terminate the life of a competent patient on the basis of some prior discussion without checking to see if the patient still felt the same way.

Conservatively speaking, it is clear that more euthanasia deaths occur in cases where patients have made no request to their physician to end their lives than in cases where patients have made such a request. That this should be is remarkable in light of the Dutch insistence that euthanasia be limited to cases of voluntary request. The summary of guidelines issued by the Dutch minister of health clearly indicated that the free, voluntary, and informed consent of the patient was the touchstone of legal toleration of euthanasia. No judicial decision has ever retracted this basic

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[71] Keown II, *supra* at 269-270, Table 1.

[72] *Id.*, citing *Survey* at 133.

[73] *Id.* at 134.

[74] *Id.* at 75, Tables 7.7 and 8.7.

[75] *Id.* at 134, Table 13.5.

requirement.[76] Yet, the incidence of nonvoluntary euthanasia was apparently widespread at the time these guidelines were issued (the Survey was conducted in 1990), and is now defended in medical and official governmental circles. A government report issued in conjunction with the Van der Maas Survey referred to cases in which physicians had terminated the lives of patients without request as appropriate "care for the dying" and as part of normal medical practice.[77] The clear implication is that it is not patient consent, but "unbearable suffering," "low quality of life," poor prognosis for recovery, and the fact that the patient has "entered the dying phase of life" that form the real justification for tolerance of euthanasia.[78]

A number of Dutch euthanasia advocates have admitted that practicing euthanasia with legal sanction has encouraged doctors to feel that they can make life or death decisions without consulting even competent patients. To illustrate this point: in one case, a doctor terminated the life of a nun a few days before she would have died because she was in excruciating pain, and her religious convictions did not permit her to request euthanasia.[79] In cases such as these, "the patient has no autonomy because the

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[76] In similar vein, the court of appeals has proposed that the "critical line" in cases involving both physician-assisted suicide and the forgoing of life-sustaining treatment is "the one between voluntary and involuntary termination of an individual's life." 79 F.3d at 832. Yet, the accompanying footnote clearly indicates that the line would be as movable under the logic of this decision as it has been in the Netherlands:

> While we place euthanasia, as we define it [ending a patient's life as an act of mercy, but not upon request], on the opposite side of the constitutional line we draw *for purposes of this case*, we do not intimate any view as to the constitutional or legal implications of the practice.

Id. at 832, n. 120 (emphasis supplied).

[77] Keown II, *supra* at 276-277.

[78] Hendin, *supra* note 26 at 89.

[79] *Id.* at 79.

doctor has decided that the quality of the patient's life is such that it is time for the patient to die.[80]

V. LEGAL SANCTION FOR EUTHANASIA HAS IMPAIRED THE TREATMENT OF DEPRESSED SUICIDAL PATIENTS IN THE NETHERLANDS AND WOULD DO SO IN THE UNITED STATES.

What happens in the Netherlands to patients who become suicidal in response to serious or terminal illness is illustrated by a case presented in a film, *An Appointment with Death*,[81] distributed by the Dutch Voluntary Euthanasia Society. Although the film was intended to promote euthanasia, it provides an example of how a physician's inability to deal with a patient's fear of death led to a premature ending of the patient's life.

A forty-one year old artist was diagnosed as HIV positive. He had no physical symptoms, but had seen others suffer with them and wanted his physician's assistance in dying. The doctor compassionately explained to him that he might live for some years symptom-free. Over time the patient repeatedly requested euthanasia and eventually his doctor acceded to it.

The man was clearly depressed and overwhelmed by the news of his situation. The doctor kept establishing that the patient was persistent in his request, but did not address the terror that underlay it.

Consultation in the case was pro forma. A colleague of the doctor's saw the patient briefly to confirm his wishes. With a psychologically sensitive physician able to deal with more than whether his patient meet criteria regarding his request to die, more likely in a culture not so accepting of euthanasia, this man would not have needed to be put to death.

The doctor thought his patient was acting unwisely and prematurely. Not knowing how to deal with his patient's terror, he

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[80] *Id.* at 90.

[81] *An Appointment with Death*, K.A. Productions (1993).

rationalized that respect for the patient's autonomy required that he go forward.

This attitude, which was typical of Dutch doctors in dealing with patients who become suicidal in response to illness, has obviously had an impact on the treatment of suicidal patients in the Netherlands. In the past decade by making assisted suicide and euthanasia easily available, the Dutch have significantly reduced the suicide rate of those over fifty in the population. Comparing the five years of 1980-1984 with the 1988-1992 years provides statistically significant evidence of a drop in the older age group that is not due to chance.

This is the age group containing the highest numbers of euthanasia cases (86% of the men and 78% of the women) and the greatest number of suicides. The past decade is the period of growing Dutch acceptance of euthanasia. The remarkable drop in the older age group appears to be due to the fact that older suicidal patients are now asking to receive euthanasia. The likelihood that patients would end their own lives if euthanasia were not available to them was one of the justifications given by Dutch doctors for providing such help.

Of course, euthanasia advocates can maintain that making suicide "unnecessary" for those over fifty who are physically ill is a benefit of legalization rather than a sign of abuse. Such an attitude depends, of course, on whether one believes that there are alternatives to assisted suicide or euthanasia for dealing with the problems of older people who become ill.

In this country, as well as the Netherlands, among an older population physical illness of all types is common. Some who have trouble coping with physical illness became suicidal. In a culture accepting of euthanasia their distress is accepted as a legitimate reason for dying. It may be more than ironic to describe euthanasia as the Dutch cure for suicide.

What parallels do we already see or are we likely to see in the Dutch experience to our own? Our legal system as well as our medical and ethical values would make it difficult for use to make a distinction between assisted suicide and euthanasia. Nor if we

recognize a right to assisted suicide and or euthanasia would we find it easy to exclude people who are suffering but are not terminally ill.

The leading medical advocates of assisted suicide in the United States have authored model proposals that make clear that legalization of assisted suicide for terminally ill patients is but a first step. Timothy Quill and five co-authors, for example, call in the *New England Journal of Medicine* for legalization of euthanasia as well as assisted suicide not only for "competent patients suffering from terminal illness" but also for those with "incurable, debilitating disease who voluntarily request to end their lives" "Incurable debilitating disease" could include conditions like diabetes and arthritis.[82]

The Chabot case aroused such concern outside of the Netherlands that we are not likely to see pressure for assisted suicide or euthanasia for distress unaccompanied by physical illness for some time. Psychological distress, however, is most often at the basis of the request for assisted suicide even when the patient has a physical illness. If legalization occurs the combination of the two is as likely to be accepted as justification for euthanasia here as it is in the Netherlands.

There is every reason to believe that in this country just as in the Netherlands giving physicians the power to end life will encourage many to make such decisions without consulting patients. Some admit to having done so already.[83]

The American cases of assisted suicide published as models intended to persuade us of the benefits of legalization — such as Quill's Diane and Compassion in Dying's Louise — reveal the same problems as Dutch cases and indicate that American doctors are no different than Dutch doctors when deciding to utilize assisted suicide.

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[82] F.G. Miller, et al. *Regulating Physician-Assisted Death*, 433 New Eng. J. Med. 119 (1994).

[83] Anon., *It's Over, Debbie*, 259 JAMA 272 (1988).

The public has the illusion that legalizing assisted suicide and euthanasia will give them greater autonomy. The Dutch experience teaches us that legal sanction for assisted suicide and euthanasia actually increases the power and control of doctors who can suggest or encourage it, not propose obvious alternatives, ignore patients' ambivalence about suicide, and even put to death patients who have not requested it.

Conclusion

For all the forgoing reasons, and for the reasons urged by the Petitioners and their *Amici* in the instant case and in *Quill* v. *Vacco* (No. 95-1858), the judgments of the Ninth and Second Circuits should be reversed and the complaints dismissed.

Respectfully submitted,

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In The

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October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

v.

Petitioners,

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

v.

Petitioners,

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF *AMICI CURIAE* OF AMERICANS FOR DEATH WITH DIGNITY AND THE DEATH WITH DIGNITY EDUCATION CENTER IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI*

Americans for Death With Dignity is a California nonprofit corporation. Its constituency, numbering approximately 25,000 persons, includes physicians, clergy, attorneys, terminally ill persons, their friends and families, and others who support the right to physician aid in dying for mentally competent, informed, terminally ill adults.

Americans for Death with Dignity wrote, qualified, and sponsored Proposition 161, an initiative on the November 1992 general election ballot in California. Proposition 161 would have given competent, informed, terminally ill patients the right to request and receive physician aid in dying. Despite a well financed opposition, the measure received 4,562,010 votes, or 46% of the votes cast.

Americans for Death with Dignity believes that a competent, terminally ill adult has a right to choose a peaceful, pain-free and dignified death. For many terminally ill persons, this right cannot be humanely exercised without the aid of a compassionate physician. Americans for Death with Dignity supports reasonable regulation of access to physician aid in dying to ensure that it is not abused.

The Death with Dignity Education Center, based in San Mateo, California, is a national not-for-profit 501(c)(3) organization, founded in 1994. Its mission is to promote a comprehensive, humane, responsive system of care for terminally ill patients.

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*This Brief is filed with consent of all the parties. The letters granting consent are separately lodged.

The Center fosters discussion about physician aid in dying, provides a common meeting ground for dialogue and consensus-building, and develops effective goal-oriented strategies for advancing issues related to end of life care. It serves as an information resource for the public and the media, providing factual, up-to-date information that is balanced, authoritative, and understandable. It extends outreach to established constituencies and professional organizations to encourage them to become involved in the discourse and deliberation surrounding these issues. The Center's goal is to develop the framework for public consensus and the messages that will support it.

INTRODUCTION

How can a competent, terminally ill adult end her suffering and lawfully hasten death in the State of Washington?

> She can take a gun to her head, if she can get it and dares to use it.
>
> If she is lucky enough to be on a life support system she can have a physician disconnect the system and thus die "naturally" by starvation, dehydration or suffocation.
>
> But she can't have a physician prescribe a medication that will bring a quiet, painless and dignified end to her suffering.

The State thus places a higher value on "allow[ing] the disease process to follow a natural course to death,"

Pet. Br. 12,[1] than it does on self-determination, ending suffering and sustaining dignity. That is the crux of the State's position at virtually every step of the argument in this case. The State's view of the Constitution – and, indeed, of life – is cruel, degrading, arbitrary and wrong. The Court should affirm the court of appeals' decision and affirm individual liberty against state power. Anything less would be uncivilized.

ARGUMENT

This case presents one of the great issues of our day: the right of mentally competent, terminally ill adults to exercise their constitutionally protected right of self-determination and individual liberty by hastening death with the assistance of a physician. But, while this issue is great, it is also narrow. Unlike the traditional "suicide" who intends to take his life, the terminally ill person who seeks physician aid in dying does not have the primary goal of ending his life – nature has taken care of that. The person who seeks physician aid in dying wants to end his suffering by shortening the dying *process*. No state has a legitimate interest in prolonging the suffering of the dying.

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[1] Citations to "Pet. Br." refer to the Brief Submitted by Petitioners in *Washington v. Glucksberg*, Case No. 96-110. This brief is filed primarily in response to the arguments made by the State of Washington in the *Glucksberg* case. However, the arguments presented in this brief apply with equal force to the other case before this Court, *Vacco v. Quill*, Case No. 95-1858.

I. THE CONSTITUTION PROTECTS THE RIGHT OF A TERMINALLY ILL ADULT TO HASTEN DEATH.

The constitutionally protected right to self-determination and personal autonomy encompasses the right of a terminally ill adult to end his or her suffering by hastening death with the aid of a physician. The right to self-determination and personal autonomy is imbedded in our nation's tradition. More than a hundred years ago, this Court declared:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

The Court has relied upon this deeply-rooted right to protect an individual's freedom to decide the course of his or her life. For example, this Court invoked the "liberty interest" to protect the right to procreate, *Skinner v. Oklahoma*, 316 U.S. 535 (1942); to protect personal decisions relating to marriage, *Loving v. Virginia*, 388 U.S. 1 (1967); to protect the rights of both married and unmarried persons to use and have access to contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); and to protect a woman's right to have an abortion. *Roe v. Wade*, 410 U.S. 113 (1973).

The Court stated the principle eloquently in *Casey*:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 851 (1992).

Like other "liberty interests," the right of a terminally ill adult to determine the time, place, and manner of her death involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. Like a woman who faces an unwanted pregnancy, a terminally ill patient faces "suffering [that] is too intimate and personal for the State to insist, without more, upon its own vision . . . however dominant that vision has been in the course of our history and culture." *Id.* at 852.

Indeed, in *Cruzan* this Court recognized that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 281 (1990). The *Cruzan* dissenters agreed:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental."

Id. at 343 (Stevens, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

> Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

Cruzan, 497 U.S. at 310-11 (Brennan, J., dissenting).

In *Cruzan*, the Court concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. Implicit in this statement is the principle that a competent, terminally ill person has a constitutionally protected liberty interest in hastening death, since refusing life-sustaining medical treatment is choosing to die sooner rather than later. In short, this Court in *Cruzan* recognized that a terminally ill patient has a right to hasten death by effectively starving herself to death.

The State not only agrees that such a right exists, Pet. Br. 12, but protects it by statute. RCW § 70.122.010, *et seq.* Accordingly, the State allows a competent, terminally ill person to starve herself to death but does not allow her to ease her way into death by the use of physician-prescribed medication. This position is irrationally cruel, and the State fails to identify any significant difference, in terms of the liberty interest, between these two situations.

Mrs. B's experience aptly illustrates this false dichotomy. At age sixty, Mrs. B had suffered from an aggressive form of breast cancer for ten years. After five years of frequent hospitalizations, surgeries, hormonal therapies, chemotherapy, and radiation, she was rendered bed-

bound and housed in a nursing facility. As she became weaker, and could neither read nor take care of her basic bodily functions, she found her continued "living" unbearable. She turned to her physician for assistance in ending her suffering. After consulting with the hospital ethics committee, the physician outlined the only method by which she could help – Mrs. B would be given intravenous morphine and sedation to leave her unconscious, then be "allowed to die" of dehydration. After saying good-bye to her family and friends, Mrs. B was given the medications intravenously. She lingered for ten days in an unconscious state before succumbing to dehydration. *See* Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* (1993), 111-112.

Moreover, the withdrawal of life-sustaining treatment is no less an *active* step hastening death than the provision of a prescription in response to a competent, terminally ill adult's request. In fact, the act of removing a respirator or withholding life-sustaining nutrition or hydration may be far more intrusive than prescribing medication. When a physician removes a respirator or withholds nutrition or hydration, the patient will die. When a physician prescribes medication, the patient may or may not choose to take the medication. In both instances, it is the patient's wish that operates to hasten death.

Thus, the right of a mentally competent, terminally ill adult to hasten death is a liberty interest protected by the

Due Process Clause from unwarranted governmental interference.[2]

II. THE RIGHT TO END PERSONAL SUFFERING OUTWEIGHS ANY STATE INTEREST IN PROLONGING THE DYING PROCESS.

This liberty interest must be balanced against any competing interests a state might have. *Cruzan*, 497 U.S. at 279. However, the state may not destroy – outright or through restrictions that have the same effect – an individual's ability to exercise his liberty interests. *Casey*, 505 U.S. at 857, 874 ("a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims;" state regulations which impose an "undue burden" on a woman's ability to make the decision to terminate her pregnancy violate the Due Process Clause).

A. The State's Asserted Interests Are Weak.

Although the State asserts a number of interests in banning physician aid in dying, those interests pale in comparison to the interests of the terminally ill people who wish to humanely hasten the dying process.

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[2] Since there is no constitutionally cognizable difference between allowing a person to starve herself to death and allowing a person to hasten death through the use of physician-prescribed drugs, the statute at issue in this case also violates the Equal Protection Clause.

1. Preservation of Life

The State argues that its interest in preserving life outweighs the right of an individual to hasten death with the aid of a physician. Pet. Br. 33-38. This argument ignores a long line of cases, from this Court and others, that recognizes that the state's interest in preservation of life is neither absolute nor static. Rather, the state's interest in preservation of life varies depending on the stage and quality of life at issue.

As various abortion decisions and the "end-of-life" decisions demonstrate, the state's interest in preserving life is strongest in the middle point of the continuum, after viability and throughout an adult's healthy productive years. As an individual approaches death, the state's interest in preservation of life weakens. *See, e.g., Cruzan*, 497 U.S. at 271 (quoting *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977)) (state's interest is "greatest when an affliction [is] curable" and less so when " 'the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended' "); *Brophy v. New England Sinai Hosp., Inc.* 497 N.E.2d 626, 635 (Mass. 1986) (same); *Roe v. Wade*, 410 U.S. 113, 163 (1973) (describing the state's interest in life as gradually increasing during pregnancy relative to the individual's interest); *Casey*, 505 U.S. at 869 (same); *Matter of Quinlan*, 355 A.2d 647, 663-64 (state's interest in preserving life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases as the prognosis dims"), *cert. denied sub nom., Garger v. New Jersey*, 429 U.S. 922 (1976); *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987)

(state's interest in preserving life "necessarily weakens and must yield to the patient's interest" where treatment "serves only to prolong a life inflicted with an incurable condition"); *McKay v. Bergstadt*, 801 P.2d 617, 622 (Nev. 1990) ("as the quality of life diminishes because of physical deterioration, the State's interest in preserving life may correspondingly decrease").

At either end of the continuum – before viability and near death – the individual's personal autonomy interest outweighs the state's abstract interest in "preserving life." The terminally ill individuals whose rights are at issue here are at the very end of this continuum, suffering through the final stage of life with no hope of recovery. When a person approaches death and judges continued suffering and degradation to be unbearable, there is no principled state interest in forcing that person, against her will, to prolong the suffering and dying process.[3]

Indeed, the State admits that there is a "well settled" right to hasten death by refusing life-sustaining medical treatment, including refusal of nutrition and hydration. Pet. Br. 12. *See, e.g., In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), *amended*, 757 P.2d 534 (Wash. 1988). It apparently believes its interest in preserving life must yield to that right because hastening death through

[3] Similarly, Washington contends that physicians must act only for "therapeutic purposes." Pet. Br. 13. Is it "therapeutic" to prolong life and suffering when death is certain and imminent? Is it therapeutic to remove a patient's food and water to hasten death because of her "physiological inability to chew or swallow," Pet. Br. 38, but not to give that same patient a prescription for medication that will bring a painless and dignified end to her suffering?

refusal of medical treatment "allows the disease process to follow a natural course to death" – which may be "set in motion by [the patient's] physiological inability to chew or swallow." Pet. Br. 38, citing *In re Gardner*, 534 A.2d. 947, 955-56 (Me. 1987).[4]

The State's "preservation of life" rationale thus rests on a cruel and untenable preference for death by starvation or dehydration, which will likely cause suffering for well over a week, over a quick, painless and dignified death through self-administered medication. Surely the Court would not condone such a state preference were this an Eighth Amendment case.

2. "Erroneous" Deaths.

The State also argues that it has an interest in prohibiting "deaths that occur as a result of errors in medical or legal judgment." Pet. Br. 34. Its premise is that "it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is impossible to say for certain whether a borderline individual is or is not mentally competent." Pet. Br. 34.

This argument is disingenuous. Washington, like many other states, has already legislated such issues. The Natural Death Act defines "Terminal condition" as:

[4] Moreover, under Washington law, one need not even be in a persistent vegetative state to refuse nutrition and hydration. *See* RCW § 70.122.010 *et seq.* A fully conscious terminally ill person could lawfully hasten his death by refusing life-sustaining nutrition and hydration.

> an incurable and irreversible condition caused by injury, disease, or illness, that within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW § 70.122.020(9). The Legislature recognized that a directive to withhold or withdraw life-sustaining treatment may remain in effect if the declarant "becomes comatose or is rendered incapable of communicating with the attending physician." RCW § 70.122.040(3). Thus, in the context of refusing medical treatment, the Legislature has already come to terms with the issues of defining terminal illness. Those issues are no more complicated in the present context.[5]

The State also pejoratively skews the issue of mental competence. Quoting from a report of the Washington Legislative Council Committee, Dec. 3, 1970, it asserts, "[A potential suicide] is in all probability a troubled, disturbed human being who needs psychiatric care or

[5] Indeed, if terminally ill adults know that assistance is available, and that they can remain in control of their deaths, that knowledge may actually increase the will to live for many who would otherwise contemplate immediate suicide. "The fear and anxiety that many people feel when contemplating chronic and terminal debilitating illness is rooted, at least in part, in the fear that their suffering will be prolonged by medical technology and that they will have little or no control over its application." Christine K. Cassel, M.D. & Diane E. Meier, M.D., *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 No. 11, New Eng. J. Med., 750, 751 (Sept. 13, 1990).

some other counseling service." Pet. Br. 5. It also characterizes a suicide attempt as "indicative of a mental disorder. . . . " *Id.* at 23. While all this may be true of suicide attempts in the general population, this case deals with the narrow group of mentally competent, terminally ill adults who are already dying. In that context, to request a physician's assistance in hastening death is rational, not remotely "indicative of a mental disorder."

If the State wants to engage in definitional quibbles, it should recall that the statute makes a criminal of one who "aids a suicide." But is honoring a choice to end suffering and indignity by hastening an imminent death "aiding suicide"? Is that more like "suicide" than choosing to suffocate by having a respirator removed? And is removing that respirator – an act expressly sanctioned by the State – something less than "aiding"?

In fact, these "definitional" problems are paper tigers. "In the real world we have no difficulty identifying and distinguishing the terminally ill. They are patients who will die from a specific disease within a relatively short period of time." Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, Hastings Center Report (September-October 1993) at 22. *Accord Casey*, 505 U.S. at 869 ("Liberty must not be extinguished for want of a line that is clear.").

3. Abuse, Undue Influence, and the "Slippery Slope."

The State also raises the specter of abuse and undue influence. Pet. Br. 34. But, the same argument could be (and was) made in the abortion context, or, indeed, any

time an individual has a choice. The alleged risk here is no different than any risk associated with the refusal or withdrawal of life support. Even if there were a risk, the solution is not to eliminate individual choice and place absolute power in the hands of the state. The possibility of malicious third parties influencing the decision to hasten death does not nullify constitutional liberty interests.

The State further claims that affirming the constitutional right to physician aid in dying would "freeze the process of experimentation" and "forestall the opportunity to learn." Pet. Br. 49. Just the opposite is true. As the law currently stands, physician aid in dying is practiced covertly, outside of public scrutiny or discussion, and is more likely to be subject to abuse than if the practice were regulated by the state. Affirmation of the right to physician aid in dying would make the practice subject to reasonable regulations crafted to ensure that access to physician aid in dying is truly in the public interest and is not subject to abuse.

Similarly, the State and some of their *amici* warn that recognition of a liberty interest in physician aid in dying will necessarily result in people's lives being taken against their will. The State falls prey to the "slippery slope" because it refuses to focus on the specific and narrow group whose interests are at issue in this case – competent, terminally ill adults. Although the State may have a justifiable interest in ensuring that the lives of individuals are not taken against their will, that interest

has nothing to do with the right of competent, terminally ill individuals to voluntarily hasten death.[6]

B. State Interests Can Be Protected By Reasonable Regulation.

The State's absolute ban is not necessary to protect any lingering state interests. The alleged dangers of fraud, abuse, or error are avoidable through reasonable regulation of the right to receive aid in dying. As this Court recognized in *Casey*, "not every law which makes a right more difficult is, *ipso facto*, an infringement of that right." 505 U.S. at 873. Indeed, this Court has repeatedly recognized that constitutionally protected liberty interests may be subject to reasonable regulation. *See Loving v. Virgina*, 388 U.S. 1 (the right to marry is a protected liberty interest) and *Potter v. Murray City*, 760 F.2d 1065 (10th Cir.), *cert. denied*, 474 U.S. 849 (1985) (the government may bar polygamy); *Roe v. Wade*, 410 U.S. 113 (women have a constitutionally protected right to decide whether to carry a child to term) and *Casey*, 505 U.S. 833 (the state may impose certain restrictions on access to abortions). Here, regulated physician assisted death would provide protocols and safeguards missing in the present, covert, unregulated context.

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[6] Contrary to the concerns of some *amici*, recognition of a liberty interest in physician aid in dying does not mean that every medical professional will be required to assist every such patient who seeks assistance. Indeed, precisely because life and death decisions are so profoundly personal, such a requirement would arguably trespass upon the physician's own liberty interests.

Several models for regulation of access to aid in dying have been proposed. For instance, the Michigan Commission on Death and Dying, composed of members from all sections of the legal, medical and lay community, formulated a proposal that would permit terminally ill, competent people to seek aid in dying under tightly controlled circumstances. *Final Report of the Michigan Commission on Death and Dying*, June 8, 1994.[7] Under this approach, physician aid in dying would be available to a terminally ill person who made a recorded request for assistance in dying. The request would have to be reiterated to a physician and witnessed two more times, with at least seven days elapsing between the reiterations. Only the terminally ill individual could make the request, and no one else could influence or determine the timing of the assistance if it was given. *Final Report*, Section III, 3. The proposal also calls for psychological and spiritual counseling, aggressive pain management and counseling on independent living alternatives before an eligible person is permitted to act on his or her request to receive aid in dying. *See also* Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) (imposing similar conditions to safeguard against misuse or abuse, including waiting period, corroboration, professional consultation, documentation and monitoring requirements).

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[7] The Michigan Commission produced three reports with different recommendations; none of the recommendations was endorsed by a majority of the members of the Commission.

C. The Washington Statute Unduly Burdens The Right Of A Mentally Competent Terminally Ill Adult To End Suffering By Hastening Death.

1. The State's Ban on Physician Aid in Dying Strips Many Terminally Ill Adults of Their Ability to Hasten Death.

The Washington statute prohibits physicians from assisting mentally competent, terminally ill individuals to hasten death.[8] Under the statute, a physician cannot prescribe medication to a terminally ill patient if the physician knows that the medication will be used to end the patient's life. While terminally ill people may be able, legally,[9] to hasten death through other means (by shooting themselves, for example), most terminally ill people are confined to institutions and do not have access to those means, are too weak to use them, or are averse to the violence these means often entail. Worse yet, the legal options currently available to the terminally ill are far less humane than the administration of medication that will hasten death.

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[8] The Washington statute states, "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." RCW 9A.36.060(1). Violation of this law is punishable by imprisonment for up to five years and by a maximum fine of $10,000. RCW 9A.36.060(2) and RCW 9A.20.020(1)(c).

[9] The act of suicide is not illegal in any state. *See* Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 377 (1992). Only the act of assisting suicide is illegal.

Changes in medical technology and in the way that Americans die are important factors in the analysis of an individual's right to die:

> "[T]he timing of death – once a matter of fate – is now a matter of human choice." . . . Of the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, and perhaps 70% of those after a decision to forgo life-sustaining treatment has been made. Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.

Cruzan, 497 U.S. at 302-03 (Brennan, J., dissenting) (citations and footnotes omitted). Similarly, "[p]eople are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions." *Id.* at 339-40 (Stevens, J., dissenting).

Today, 80% of Americans – the vast majority of us – die in hospitals or long term care facilities, in many cases with little or no control over the end of our own lives. When we enter a hospital for the last time, we may have the strength, and technically, the legal right to end our lives if we wish. But once in the medical system, we often

lose the ability to help ourselves. Most of us have neither the knowledge nor the means to end our own lives in an acceptable way. We can't get life-ending substances for a dignified death, even if we knew how to use them. Thus, as a practical matter, competent terminally ill individuals frequently cannot exercise their right to hasten death without the assistance of a physician.

> To say the least, a ban on the use of physician-prescribed medications obviously places a substantial obstacle in the path of a terminally ill person seeking to hasten that person's inevitable death. Indeed, a more extreme burden on the exercise of that right cannot be imagined, and for this reason . . . the ban on the use of physician-prescribed medications is unconstitutional.

Sedler, *The Constitution and Hastening Inevitable Death* at 23.

The continuing criminalization of physician aid in dying hurts patients and their families and inhibits compassionate physicians from helping patients even when they are unable to cure their illnesses. The State insists on comparing a humane medical procedure to murder. Pet. Br. 6, 11 (assisted suicide laws "are generally considered part of the State's homicide laws . . . "; "[O]ne who intentionally acts to cause or contribute to another's death is with rare exceptions guilty of criminal conduct."). Thus the present system condemns dying people who cannot bear their pain any longer and makes closet felons out of compassionate doctors who respond to the last-resort requests of their suffering patients. One oncologist who repeatedly faced this dilemma stated:

> There are cases that stand out in my mind – more than ten – where I was helpless to relieve my patient's suffering, despite aggressive treatment. It made me feel awful. . . . Some of them made requests like "Put me out of my misery." Legally I couldn't do that. . . . I felt that I was abandoning them, but my hands were tied.

Sarah Henry, "Whose Life Is It, Anyway"? *California Lawyer*, September, 1996 at 32.

If the constitutionally protected right to hasten death is to have any meaning, it must include the right to physician assistance:

> The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. The right should . . . include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible. . . . If there is a time when we ought to be able to get the "government off our backs" it is when we face death – either by choice or otherwise.

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1147-1148 (1986) (Compton, J., concurring).

The right of a competent, terminally ill person to physician assistance in dying is supported by constitutional jurisprudence and required by the reality of our modern world. To deny that right is to deny the most basic opportunity for self-determination.

2. The State's Ban on Physician Aid in Dying Can Devastate Terminally Ill People, Their Families, Friends and Physicians.

Under the current law, terminally ill patients who wish to hasten death are left with few options: (1) they can take their own lives through violent means, or (2) they can enlist the aid of friends and family members who may later be subject to criminal sanction.[10] This categorical ban on physician aid in dying only leads to greater suffering for the terminally ill and devastating consequences for family and friends. Like the back-alley abortions prevalent before *Roe v. Wade*, the State's categorical ban on physician aid in dying has not stopped terminally ill people from hastening death; it has merely forced them to choose violent and painful means of ending their suffering because no other options are available.

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[10] The assertion that pain can be controlled in most cases adds nothing. First, it says nothing about those terminally ill persons whose pain cannot be "controlled," and it is precisely these people for whom this case is perhaps most important. Second, it ignores the fact that pain control, in some instances, is achieved only with significant side effects such as confusion, hallucination, nausea, vomiting, constipation and respiratory depression. R. Hillier, M.D., *Control of Pain in Terminal Cancer*, British Medical Bulletin (1990) vol. 6, no. 1 at 279-91. To many, a choice between unbearable pain and loss of mental alertness may be no choice at all. "Living" under either condition may not be within the purview of what makes life worth living. Third, controlling pain is no answer for other kinds of suffering – the loss of dignity that may result from immobility, the inability to speak or swallow, incontinence, and the need for 24-hour-a-day care – that often motivate competent, terminally ill adults to seek physician assistance in hastening death.

> Self-inflicted gunshot, hanging, and asphyxiation all occur, though they may require more strength and energy than many terminally ill patients possess. If successful, patients who use these means to end their lives at least put an end (if gruesome) to their suffering. The victims more often are the families, who may both literally and figuratively have to pick up the pieces.

Quill, *Death and Dignity: Making Choices and Taking Charge*, 114.

Although the State refers to dying, suffering persons as "hypothetical people," Pet. Br. 10, 39, 40, there is nothing hypothetical about the dying people who originally brought this suit. Nor is there anything hypothetical about Bill, an energetic man in his mid-70s, who was dying from throat cancer. After 18 months of treatment, the tumor had spread to Bill's brain and sinuses and Bill had permanently lost most of his hearing, could not swallow solid foods or liquids, had constant headaches, and the drainage from his nose was so severe that he had to wear a pad. After two years of progressive deterioration and indignity, Bill decided to take his life. Since he did not want to subject his friends and family to criminal sanction, he shot himself in the head. After hearing the gunshot, Bill's wife found him, horribly wounded, but still alive. Bill died at the hospital three hours later. *See* Quill, *Death and Dignity: Making Choices and Taking Charge*, 117-120.

Moreover, terminally ill individuals who are determined to end their suffering frequently turn for help to friends or family members who may be subject to criminal sanctions. Another typical example is the story of

Steven who, just shy of his 40th birthday, was dying of AIDS. He enlisted the assistance of an HIV-positive friend. On the appointed night, Steven threw a wake party which was attended by many supportive friends and family. But the plan Steven and his friend had agreed upon went awry. Steven's friend got drunk and became increasingly distraught. When the friend nonetheless began to honor his commitment to Steven, he was interrupted mid-injection by someone and promptly left the house. Those remaining at the party were forced to call a physician who reluctantly told them how to complete Steven's directive. They all faced the risk of criminal liability. *See* Lori Olszewski, *One Man's Choice*, San Francisco Chronicle, Oct. 19, 1992.

The stories of Bill and Steven are not hypothetical or unique, and they did not have to happen. If Bill and Steven had been able to request the assistance of a physician, they could have ended their lives painlessly, with dignity, and without jeopardizing their loved ones. Despite the state's generalized interests in the "preservation of life," the state had no interest in prolonging the dying process for either of these men. Bill and Steven were not abstractions. They were people who had a right to determine how they would die. As Justice Stevens stated in *Cruzan*, 497 U.S. at 356-57 (Stevens, J., dissenting):

> However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in

> abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life.

Physician aid in dying for mentally competent terminally ill adults lets dying people be treated as individuals and not as abstractions. No state has a paramount interest in prolonging the suffering of a terminally ill adult who has competently made the decision to end the dying process.

CONCLUSION

The decision of the United States Court of Appeals for the Ninth Circuit should be affirmed.

DATED: December 10, 1996

Respectfully submitted,

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Nos. 95-1858 and 95-1

In the

Supreme Court of the United States

October Term, 1996

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Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

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BRIEF *AMICUS CURIAE* OF LAW PROFESSORS IN SUPPORT OF RESPONDENTS

INTEREST OF THE AMICI CURIAE

Amici are professors of law who lecture, write, and provide legal counsel in the areas of Constitutional Law, Criminal Law, and the field of Law, Medicine and Bioethics. *Amici* have widely diverse perspectives but are united in the convic-

tion that this Court should affirm the lower courts' decisions on the ground that the current regime of regulation of physician-assisted suicide represents a thoroughly irrational means for attempting to protect patients from abuse. Rather than protecting patients, the current legal regime actually encourages abuse. In addition, the current regime leaves individual physicians and other health care professionals uncertain as to which of their actions may be found illegal and whether they will have their lives destroyed by an exercise of prosecutorial discretion. *Amici* have filed this brief because of their concern that, for the foregoing reasons and the reasons set forth in their brief, the statutory schemes at issue here undermine respect for law, the rule of law, and the democratic process.

SUMMARY OF ARGUMENT

The State regimes overturned by the lower courts were properly found unconstitutional. Broad distinctions between physician-assisted suicide, on the one hand, and "letting patients die," on the other, are no longer rationally employed by the States to protect patients from abuse. Indeed, they are currently employed in a fashion which exacerbates the risk of abuse. Thus, these regimes are no longer rationally related to the purposes which Petitioners claim they were designed to advance.

Because the law has not kept pace with developments in medical technology, state courts have increasingly carved out exceptions to assisted-suicide laws so as to accommodate the needs of health care personnel and their suffering patients. The exceptions have by this time left little of the rule. In addition, increasing numbers of medical personnel regularly exceed the limits of these exceptions to provide covert assistance in suicide to suffering patients. Little attempt, if any, is made to uncover and prosecute these instances of physician-assisted suicide.

This regime exposes patients to greater risk of abuse than

they would be subject to under a regime of legalized and regulated physician-assisted suicide. As the available literature demonstrates unequivocally, physician-assisted suicide takes place irrespective of whether it is legally permissible or not. To the extent that it is kept strictly criminal, the acts are performed "in the closet" — leaving individual health care professionals to make critical decisions without oversight, without regulation, and without the participation of other health care personnel. On the other hand, to the extent that it is permitted to be practiced on the theory that the physician is "just letting a patient die," individual health care professionals are again left without adequate oversight, regulation, and participation from other health care personnel. By maintaining a broad distinction between merely "letting a patient die" and physician-assisted suicide, the State regimes take (and encourage others to take) decisions to engage in the former much less seriously than decisions to engage in the latter.

Should the decisions below be reversed, important interests will suffer. In addition to being placed at increased risk of abuse, patients will be handicapped in finding adequate relief from inhumane and unnecessary burdens in the dying process. Health care professionals will be forced to operate under legal uncertainty — not knowing whether a particular decision amounts to permissible withholding of life support or impermissible assistance in suicide. Finally, a reversal would undermine the overarching interests of the State in preserving respect for law and the rule of law, and its interest in the proper functioning of democratic processes.

ARGUMENT

THE STATE REGIMES OF REGULATION OVERTURNED BY THE LOWER COURTS ARE UNCONSTITUTIONAL BECAUSE THEY HAVE BECOME IRRATIONAL MEANS FOR ADVANCING THE STATE INTERESTS THAT ARE ALLEGED TO JUSTIFY THEM.

The State legislative regimes involved in these cases violate the Fourteenth Amendment to the United States Constitution because they bear no rational relation to the advancement of the State interests that have been put forward in support of these regimes. *See Allegheny Pittsburgh Coal Co.* v. *County Comm'n of Webster County*, W. Va., 488 U.S. 336 (1989); *see also Clark* v. *Jeter*, 486 U.S. 45 (1988); *City of Cleburne* v. *Cleburne Living Center*, 473 U.S. 432 (1985).

The Solicitor General, in the brief he has submitted in No. 96-110, argues that it is the State interest in protecting the many patients who might be abused if physician-assisted suicide were to be legalized that justifies burdening the liberty interests of the few patients who are forced to suffer when that option is denied them. Br. of Solicitor General at 18-19. In No. 95-1858, he argues that the same interest justifies the distinction that the States maintain between "letting nature take its course," on the one hand, and "physician-assisted suicide," on the other. Br. of Solicitor General at 9. Although the Petitioners and the *amici curiae* who have filed briefs on their behalf make this point in a variety of ways, they are essentially in agreement with the Solicitor General that it is the threat of the abuses that might follow legalization that justifies holding the line against physician-assisted suicide.

However, in drawing the line as they do in prohibiting physician-assisted suicide, the States are actually exacerbating the risks of abuse of patients. Rather than bearing a rational relation to the goal of protecting patients from abuse, the State legislative regimes found unconstitutional by the Courts of Appeals for the Second and Ninth Circuits actually expose

patients to a greater risk of abuse than would be faced under a regime that permitted and regulated physician-assisted suicide.

A. *The current regimes no longer make any rational use of the distinction between physician-assisted suicide and refusal of life-prolonging treatment.*

It is no surprise that State court judges deciding the first "right to die" cases felt it necessary to develop a bright line distinction between suicide and refusal of treatment. The law had not kept pace with developments in medical technology that had created situations where continuation of life-prolonging treatment could seem senseless and even cruel from the point of view of the patient, the patient's family, and the medical personnel involved. Criminal laws regarding homicide and assisted suicide did not make exceptions for cases where the patient begged for death.

In an environment of legislative inactivity on the subject, common law courts acted to provide relief in individual cases in a fashion that would not obviously conflict with the then-governing law. In *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), for example, the Supreme Court of New Jersey was asked to authorize the removal of a patient from a ventilator so that she could die rather than be forced to continue to exist in a persistent vegetative state. No evidence was introduced that Karen Quinlan would have felt mechanical ventilation to be a particularly intrusive or offensive medical technique. Presumably she would have been willing to be maintained on mechanical ventilation so long as it promised a future in which she would have preferred life over death. But Ms. Quinlan's father thought she would rather be dead than be maintained in a persistent vegetative state. In granting the right to remove her from the ventilator so that she could die, the New Jersey Supreme Court noted the fact that many might see this as an act of assisting suicide. In reply, all the court could muster was one sentence: "We would see,

however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." *Id.* at 43, 355 A.2d at 665.

Similarly, in *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), the Supreme Judicial Court of Massachusetts felt it necessary to draw a bright line between physician-assisted suicide and termination of life-sustaining treatment on request. Again, the court gave short shrift to the effort to justify this distinction. In an important footnote, the court said:

> The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 743, n.11, 370 N.E.2d at 426, n.11 (citations omitted).

The *Saikewicz* case itself involved a cancer patient whose life would have been extended for only a short period by chemotherapy. The treatment did not offer any hope of cure, and, in recognizing Mr. Saikewicz's right to refuse chemotherapy, the court claimed that his death was

"inevitable" in the sense that the treatment was only "life-prolonging" and not "life-saving."

In later cases, however, the Massachusetts courts extended the right to refuse treatment to embrace situations where treatment was clearly to be classified as "life-saving." For example, in *Lane* v. *Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978), a patient was permitted to refuse amputation of a gangrenous leg despite the fact that the amputation would have extended her life indefinitely. In *Commissioner of Correction* v. *Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979), the Supreme Judicial Court stated in dictum (and later held in *Matter of Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980)) that patients had the right to refuse life-saving kidney dialysis. In *Lane* and *Spring*, the opinions made no effort to explain how the refusals of life-saving treatment differed from suicide. In *Myers*, the court said only that Myers death "from a refusal of medication or dialysis [would not] necessarily constitute suicide. Rather, his death would result from 'natural causes' since he would not have 'set the death producing agent in motion' with the 'specific intent' of causing his own death." 379 Mass. at 262, 399 N.E.2d at 456.

In *Brophy* v. *New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986), the Massachusetts court took the next step and recognized a right to refuse life-maintaining treatment where the "specific intent" of the patient was to cause his own death. There, the Supreme Judicial Court recognized the right of Paul Brophy to refuse food and water in order to end his continued existence in a persistent vegetative state. Doctors supplied food and water to Mr. Brophy by way of a gastrostomy tube inserted through the wall of his stomach. As with Karen Quinlan, there was no evidence that Paul Brophy would have objected to this as a particularly intrusive or offensive medical technique. Like Ms. Quinlan, he would likely have been willing to be maintained in this fashion if it had offered him a future in which he would have preferred life over death. But the evidence showed conclusively that Mr. Brophy would rather die than persist in a

vegetative state. He had frequently, clearly, and vehemently stated his objections to being kept going in a state like Karen Quinlan's. "If I'm ever like that," he once told his brother, "just shoot me, pull the plug." *Id.* at 428 n. 22, 497 N.E.2d 632 n. 22. Upon admission to the hospital, he had stated to one of his daughters, "If I can't sit up to kiss one of my beautiful daughters, I may as well be six feet under." *Id.* As a result, the court granted him the right to die by dehydration and starvation.

Three dissenters in the *Brophy* case highlighted the tension that existed between the court's holding and laws prohibiting assistance in suicide. Justice Lynch's observations on the point are representative:

> Here, Brophy is not terminally ill, and death is not imminent, and the judge specifically found that Paul Brophy's decision would be to terminate his life by declining food and water. The judge also found that "Brophy's decision, if he were competent to make it, would be primarily based upon the present quality of life possible for him, and would not be based upon the burdens imposed upon him by receiving food and water through a G tube, which burdens are relatively minimal. . . . Where treatment is burdensome and invasive, no such specific intent is normally at issue because, whether or not the patient seeks to die, the patient primarily seeks to end invasive or burdensome treatment. There is no question that the intent here is to end a life that is "over." Moreover, death here would not be from natural causes, i.e., causes he or his agents did not set in motion, but instead, the death producing agent would be set in motion by a volitional act with the intent to cause death.
>
> Suicide is primarily a crime of commission, but can, and indeed must, also be conceived as an act of omission at times. *See In re Caulk*, 125 N.H. 226, 228, 231-232, 480 A.2d 93 (1984) (suicide can be committed by starvation [or dehydration]). If nutrition and hydration are terminated, it is not the illness which causes the death but the decision (and act in accordance therewith) that the illness makes life not worth living. There is no rational distinction between suicide by deprivation of hydration or nutrition in or out of a medical setting — both are suicide.

Id. at 446-47, 497 N.E.2d 642-43 (footnotes omitted).

What has been done in Massachusetts and New Jersey has been done across the country. *See Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 271-77 (1990) (citing, among others, New York and Washington cases). State courts have essentially legalized some forms of physician-assisted suicide in order to adjust the law to the realities of modern medical technology and to provide relief to suffering patients, their families, and their medical personnel. In doing so, the courts and the medical personnel who have followed their decisions have continually developed ingenious ways to grant relief while preserving the appearance of not sanctioning suicide.

Recently, medical personnel have begun to engage in a practice called "terminal sedation." Patients who are not in a persistent vegetative state — who are conscious and competent but suffering from a terminal illness — are offered the option of being sedated to complete unconsciousness and being allowed to die of dehydration, starvation, or some intervening complication. *See* J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996); Katherine M. Foley, *Pain, Physician-Assisted Suicide and Euthanasia*, 4 Pain Forum 163 (1995); I. R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25 (1993); N. I. Cherney and R. K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994); R.D. Troug, et al., *Barbiturates in the Care of the Terminally*

Ill, 327 N. Eng. J. Med. 1678 (1991).[1] With the advent of such techniques of "refusing treatment" as "terminal sedation," very little seems left to the category of the sort of physician-assisted suicide that is still to be deemed a crime. What does remain seems to serve only as a foil for legitimating everything else that has been allowed. "Physician-assisted suicide," so-called, has become merely a symbol — the thing that every new technique for hastening death claims not to be in order to establish respectability.

Moreover, even those acts that are thought still to constitute prohibited physician-assisted suicide are regularly practiced in the United States. In March 1996, the Journal of the American Medical Association published an article documenting that physicians in the State of Washington commit acts of physician-assisted suicide and euthanasia in percentages that rival those in Holland, where euthanasia and physician-assisted suicide are essentially legalized. *See* Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996):

> Washington physicians receive requests for physician-assisted suicide or euthanasia almost as frequently as Dutch physicians. Also, physicians in both places grant approximately the same proportion of requests. Our study indicates that in Washington, 24% of patient requests for physician-assisted suicide or euthanasia are ultimately granted; in the Netherlands, less than a third of requests are ultimately granted. Of course, Washington differs from the Netherlands in at least two salient respects, namely, the criminal status of physician-assisted death and the absence of universal health

[1] *See also*, Warren Wolfe, *Three lives, three journeys: Ken/A life, a death, a legacy*, Minneapolis Star Tribune, Feb. 27, 1994, at 14A (describing sixty-two year old, competent nursing home resident who dehydrated and starved himself to death with comfort care provided by nursing home staff).

> coverage. However, these empirical comparisons suggest that patients in both places make these requests regardless of legal constraints on physicians or medical care delivery systems.

Id. at 924 (footnotes omitted).

As regards the extent to which these results are extrapolatable to the United States as a whole, the authors cited surveys conducted in four other states — D. J. Doukas, et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clin. Oncology 1055 (1995); R.S.Shapiro, et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 Arch. Int. Med. 575 (1994); S.H. Miles, *Physicians and their Patients' Suicides*, 271 JAMA 1786 (1994); and M.A. Lee, et al., *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 N. Eng. J. Med. 315 (1996) — and conclude that their data "do not suggest that a uniquely favorable degree of support exists for physician-assisted death in Washington." Back, *et al.*, 275 JAMA at 924-25.

In May 1996, the New England Journal of Medicine published an article reporting the results of a poll of 1,600 critical care nurses. The article concluded that a "comparison of the results reported here with those of [the] survey of physicians in Washington State suggests that critical care nurses in the United States may be as willing to be involved in the practice of euthanasia and assisted suicide as are some physicians." David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374, 1377 (1996) (footnotes omitted).

> Of the 1139 nurses who responded (71 percent), 852 said they practiced exclusively in intensive care units for adults in the United States. Of these 852 nurses, 141 (17 percent) reported that they had received requests from patients or family members to perform euthanasia or assist in suicide; 129 (16 percent of those for whom data were available) reported that they had engaged in such

practices; and an additional 35 (4 percent) reported that they had hastened a patient's death by only pretending to provide life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without the request or advance knowledge of physicians or others. The method of euthanasia most commonly described was the administration of a high dose of an opiate to a terminally ill patient.

Id. at 1374.

A variety of other sources have reported similar kinds of activity. A survey of the practices of physicians in the San Francisco Bay Area conducted from 1990 to 1995 revealed that 53% of the 1995 respondents "reported having granted an AIDS patient's request at least once for assistance in committing suicide. L. Slome, et al., *Attitudes Toward Assisted Suicide in AIDS: A Five Year Comparison Study*, National Library of Medicine (conference abstract available on World Wide Web at http://sis.nlm.nih/gov/aidsabs.htm) (December 9, 1996). An anonymous survey conducted by the New Hampshire Medical Society in 1994 revealed that "11 of its member physicians admitted giving dying patients lethal injections and another 22 reported granting terminally ill patients' requests for lethal doses of medication so they could commit suicide." *New Hampshire Physicians Admit Helping Patients Die, Survey Reveals*, Hemlock TimeLines, November-December 1994, at 2.

> Of the 597 respondents, 52 percent (310) said if physician-assisted suicide were legal, under certain circumstances, they would prescribe or administer a lethal dose of medication to a terminally ill patient, if requested. Another 19 percent, or 113 physicians, said they would do so even if it were illegal.

Id.; see also Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds, Boston Globe*, Feb. 28, 1992 at 5.

Although it is an "open secret" that such technically illegal practices are taking place, prosecutions and disciplinary actions against the medical personnel involved have thus far been almost non-existent. When the Journal of the American Medical Association reported what was being done by physicians in Washington, prosecutors in that State and officials of the American Medical Association expressed no shock and made no calls for investigative action. When a distinguished New York physician admitted in the pages of the New England Journal of Medicine that he had assisted a cancer patient to commit suicide by means of an overdose of barbiturates, the New York State Board for Professional Medical Conduct found that "no charge of misconduct was warranted." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times, August 17, 1991 at L-25. The physician had stated quite clearly in print that his intention had been to give his patient a prescription that she could use to end her life:

> As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort, and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible.
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>
> A week later, she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion,

it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before ending her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring — spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time that she had left, and to maintain dignity and control on her own terms until her death.

•••

Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most — increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to her husband and son that morning, and asked them to leave her alone

for an hour. After an hour, which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace.

Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). Despite Dr. Quill's clear statement of his intentions and his close involvement in the matter, the New York Board based its decision to drop disciplinary action against him on the ground that "[a]s a treating and prescribing physician, he could not know with certainty what use a patient might make of the drugs he has prescribed. Nor is it within any physician's power or authority to compel a patient to do one thing or another with any prescription. Ultimately, these are decisions left to the patients." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times at L-25.

In the view of at least one prominent legal-medical commentator, the only thing disturbing about the Quill case was that Dr. Quill felt the need to be so open and honest about his true intentions. In criticizing Oregon's initiative provision legalizing physician-assisted suicide, George Annas has argued:

[N]o changes in current law are needed to legalize the prescription of lethal drugs that have a legitimate medical use to terminally ill patients. Although the clear purpose of Ballot Measure 16 is to encourage this prescription practice, the act of putting this proposal into legislative language may itself create the erroneous impression that current legitimate prescription practices are illegal and should be discontinued.

Ballot Measure 16 may also decrease the number of physicians who are willing to prescribe potentially lethal drugs because the patient must make a request for lethal medication not because he or she will feel more secure if it is available and therefore be able to live better, but only "for the purpose of ending his or her life." Likewise, the physician's purpose

in writing the prescription must be to end the patient's life. In short, under Ballot Measure 16, the physician must agree with an explicit plan of suicide by the patient and must participate in the suicide directly and unambiguously.

George Annas, *Death by Prescription: The Oregon Initiative*, 331 New Eng. J. Med. 1240, 1242 (1994).

In the same way that the physician who gives morphine to hasten the death of a suffering patient may protect himself from a charge of euthanasia by claiming that the morphine was given only to suppress pain, the physician who assists in the suicide of a suffering patient is to be able to protect himself by claiming that he intended only to make the patient "feel more secure." Whether the physician has violated the law by assisting suicide depends upon whether others can prove that he intended to do so. The physician is thus encouraged not to discuss the case with others — even other health care professionals on the treatment team — lest she reveal her true intent.

B. *By seeking to maintain a broad legal distinction between physician-assisted suicide and refusal of life-prolonging treatment, the current regimes have placed patients at a heightened risk of abuse.*

1. *The current regimes, which encourage the widespread, covert practice of physician-assisted suicide, leave that practice totally without oversight and regulation.*

Keeping physician-assisted suicide criminal in theory while winking at it in practice creates an environment rife with opportunities for abuse of patients. Petitioners and the *amici curiae* supporting their position claim that they fear the legalization of physician-assisted suicide because there is no guarantee that it will be practiced only in an environment where patients request it competently, voluntarily, insistently,

on the basis of full information, and as a last resort. What is it about allowing it to be practiced in secret that provides the guarantees that would be lacking if it were practiced in the open? If the answer is "nothing," then we are running all the risks of abuse that petitioners fear and denying ourselves the opportunity to know what is going on and to take corrective action as it becomes necessary. By not knowing, we allow to go unchecked the very abuses Petitioners believe to be intrinsic to the practice of physician-assisted suicide. And we discourage even the open communication among practitioners and their patients that is necessary for good medical practice. The authors of the article regarding the practice of physician-assisted suicide in Washington State observed:

> Physicians are often reluctant to discuss these patients with colleagues. Five of the interviewed physicians had not previously discussed their experience with any colleague because of concern for confidentiality or discomfort with the subject. One physician had discussed the experience only after the patient had died; this physician referred the patient to a psychiatrist but did not explicitly mention the reason for the referral and noted, "You don't want everyone aware of it." One physician sought the advice of an ethics committee at the time the request occurred but found the discussion to be so constrained by legal considerations that it was not helpful.

Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 923. Fear of legal repercussions may also lead to inadequate discussion with other medical personnel and, most disturbingly, inadequate discussion with the patients themselves. As the author of the article reporting the practices of American critical care nurses reported:

> Not all reported instances of euthanasia or assisted suicide were in response to requests or performed with the

knowledge of patients, family members, or surrogates. . . . Although [the] design [of the author's study] precludes a precise assessment of the number of nurses who reported engaging in euthanasia or assisted suicide without a request from either the patient or a surrogate, it could be calculated that at least 58 nurses (7 percent) had done so at least once. Some of these instances may have occurred with the advance knowledge of patients or surrogates and so may be cases of tacit consent. For example, one nurse described her participation in the following way:

> Usually the patient has either verbalized or written several requests to have his/her suffering ended. It's like we never planned it, but having developed a relationship with the patient, we both knew when it was time. In some instances, the patient was unconscious, on an opiate drip, which I increased or failed to decrease when vital signs dropped. The only physician I've ever had an agreement with is an oncologist I work with, but it's mostly unspoken.

By a similar calculation, 62 nurses (8 percent) reported at least one instance of engaging in euthanasia or assisted suicide without a request from the attending physician.

David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. at 1376. The author concludes:

> An argument often made against physicians' performing euthanasia is that patients may come to fear physicians or distrust their motivations. I do not believe the results of this study suggest that patients or the public should fear or distrust critical care nurses. On the contrary, I think a central finding of this study is that these nurses struggle to uphold important personal values under extremely challenging circumstances — often with little support from physicians. National opinion surveys reveal

> that the majority of the public support policies that would allow euthanasia under certain circumstances. The results of this study should prompt nurses, physicians, and other health care professionals to examine their practices more openly and collaboratively, with the aim of understanding and reducing disagreement over goals and plans.
>
> •••
>
> Some may take the results presented here as a reason to permit euthanasia in specific circumstances — not just because the demand seems sufficient to result in the practice in any case, but also because by making procedures explicit, one can provide the oversight essential for protecting both patients and health care professionals.

Id. at 1378.

2. ***The current regimes, which take decisions to "let patients die" less seriously than decisions to assist suicide, leave the former decisions without adequate oversight and regulation.***

Great risk of abuse is generated as well by the stubborn maintenance of what has become the dangerous distinction between, on the one hand, committing "physician-assisted suicide," and, on the other hand, merely "letting nature take its course." Such a distinction might make sense in those cases where a patient refuses life-saving or life-prolonging treatment on the ground that the treatment itself is offensive or that the treatment would unduly detract from the quality of the time remaining in the patient's life. The terminally-ill patient who refuses treatment for his cancer so that he can enjoy his remaining days without the debilitating side effects of chemotherapy is not choosing to refuse treatment in order to cut short a life that he has come to hate. In such a case it is meaningful to say that a cooperating physician is not assisting a suicide. But when a patient is praying for death to come as swiftly as possible and, in order to bring it on,

accepts the opportunity to refuse anything that is necessary to keep him alive (food, water, antibiotics, mechanical ventilation, etc.), it is dangerous to pretend that the doctor who turns off the ventilator is not committing an act as serious (morally and legally) as the act of prescribing a lethal dose of pills. Were it not for the physician's decision, the patient would be alive. To maintain that turning off the ventilator is less serious than prescribing the pills encourages physicians to turn off ventilators under circumstances where they would not cause death if they were taking full moral responsibility for their action. *See* Mildred Z. Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14 (1993) (physicians take decision to turn off ventilator less seriously than decision to assist suicide and take decision to deny placement on ventilator less seriously than decision to turn off ventilator).

Petitioners and the *amici curiae* who support their position clearly take less seriously the decision to remove the ventilator-dependent patient from the ventilator than they do the decision to prescribe the pills. The decision to remove a patient from life support so that she may die is at least as subject to abuse as the decision to prescribe a lethal dose of pills. Yet Petitioners and the *amici curiae* who support their position do not contend that the former decisions require any of the safeguards which they claim must be in place before we legalize the latter. As a result, they put at risk of the abuses they believe are inevitable in the practice of physician-assisted suicide the vast numbers of patients who are removed from life support so that they may die.

Petitioners and their supporting *amici curiae* allege that physician-assisted suicide could lead to the following abuses:

- Coercion or undue influence that would make the patient feel forced into opting for physician-assisted suicide.

- Financial incentives that would influence the patient or caregivers to improperly opt for physician-assisted suicide (especially in this era of limited medical resources and managed care).
- Inadequate determinations of mental competence that would lead to permitting mentally-incompetent individuals to opt for physician-assisted suicide.
- Mistaken diagnoses of terminal illness that would lead to mistaken decisions to opt for physician-assisted suicide.
- Inadequate diagnosis and treatment of depression that would lead to improperly-motivated decisions to opt for physician-assisted suicide.
- Inadequate treatment for pain that would lead to unnecessary decisions to opt for physician-assisted suicide.
- Ineffective communication among medical personnel and with patients that would lead to mistaken decisions in favor of physician-assisted suicide.
- Impatience of medical personnel that may lead to too quick a decision in favor of physician-assisted suicide.

Because they do not take the decision to remove a ventilator-dependent patient from a ventilator as seriously as they do the decision to prescribe a lethal dose of drugs, Petitioners and their supporting *amici curiae* fail to recognize that the listed abuses are at least as likely to occur in the former case as in the latter. The patient who asks to be allowed to die by removal from a ventilator is at least as likely as the patient who requests a prescription for lethal drugs to be making the request because of undue influence, financial pressure, clinical depression, or inadequately treated pain. She is at least as likely to be making the decision with questionable mental competence, on the basis of a mistaken diagnosis or

prognosis, because of ineffective communication with or among medical personnel, or as a result of the impatience of medical personnel with her case. Indeed, one would think that the most likely way for medical personnel to act out impatience with a patient's case or concern regarding mounting costs of medical care would be to recommend that life-sustaining treatment just be stopped. There would be no need to recommend assisted suicide.

Likewise, the risks of an error of diagnosis or prognosis are more severe with removal from life-sustaining treatment than they are with the prescription of the lethal dose of drugs. The patient for whom the drugs are prescribed is likely never to use them if the diagnosis or prognosis turns out to be erroneous.[2] The patient who opts for terminal sedation will dehydrate to death in seven days time, whether or not the diagnosis or prognosis was accurate.

Moreover, the fact that all decision-makers are encouraged at each stage to treat decisions to "let nature take its course" less seriously than they would treat a decision to prescribe a lethal dose of medication makes the likelihood of occurrence of the various types of abuse greater in the former case than in the latter.

Maintaining the forced distinction between physician-assisted suicide, on the one hand, and termination of treatment, on the other, exacerbates the risk of abuse of patients in many ways. The fact that the boundary between the two types of acts, although theoretically strict and fraught with dire significance, is almost impossible to fix with certainty in practice is one of the causes of inadequate communication among medical personnel and patients. All parties fear that their statements may later implicate them in an act of assisting suicide. This is also a major cause of inadequate treatment for pain. The physician who uses morphine for pain must

[2] *See* Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) (noting that 39 percent of terminally ill patients who had asked for and received a lethal prescription never made use of it).

worry, among other things, that someone may later suggest that it was used not just to suppress pain, but also to shorten the life of the patient — thus subjecting her to possible prosecution for assisting suicide. *See* Miles J. Edwards & Susan W. Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 Annals of Internal Med. 254 (1992).

The unavailability of physician-assisted suicide may also lead patients to feel pressured to end their lives prematurely by refusing life-sustaining treatment. The AIDS patient who is denied the pills that he could keep at his bedside for the day when he has finally reached the end of his endurance may feel obliged to choose to die much earlier through refusing antibiotics for pneumonia at the time when chance has offered him the opportunity to do so. After all, he cannot be sure when again he will have the opportunity.

But, most fundamentally, maintenance of the distinction between physician-assisted suicide and "letting nature take its course" has exacerbated the risk of abuse by providing the conceptual foundation for a regime in which Petitioners permit patients to die by inaction with none of the protections Petitioners would require for a regime in which physician-assisted suicide were legalized.[3] *See*, for example, J. Andrew Billings and Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996), in which the authors observe as to terminal sedation:

> The slowness of the process — the series of small steps that gradually leads to death — softens the sense of the

[3] One of the very few examples of an effort to protect conscious patients who refuse life-prolonging treatment from potential abuse is *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (N.J. 1987). Even there, the protections fell woefully short of those Petitioners would require for legalization of physician-assisted suicide. The Supreme Court of New Jersey required only that "two non-attending physicians examine the patient to confirm that he or she is competent and is fully informed about his or her prognosis, the medical alternatives available, the risks involved, and the likely outcome if medical treatment is disconnected." *Id.* at 415.

physician's agency in this instance of mercy killing. The doctor and nurse may not even be nearby when the death occurs. Moreover, many physicians may have written orders on the patient and many nurses may have been involved in the care, thus diffusing responsibility.

A major concern with this form of slow euthanasia, as with many other instances of end-of-life decision making, is that issues of informed consent rarely surface: the patient is not routinely asked whether he or she desires to end life now. Death is brought on smoothly under the beneficent guidance of the medical staff. The practice is carried out openly, but decisions are usually made privately by the primary physician without outside consultation or review. The procedural safeguards that have been proposed for physician-assisted death are not regularly instituted.

Therefore, some instances of slow euthanasia by the morphine drip may be viewed as involuntary euthanasia. Life-terminating acts without explicit requests from dying patients have also been documented in the Netherlands. The existence of such practices supports concerns that we are moving down a slippery slope toward ending life without the patient's fully informed consent.

In summary, slow euthanasia by the morphine drip as described above is a common, long-standing clinical practice at the end of life, but it is not clearly acknowledged as euthanasia. Its widespread acceptance reflects a belief by physicians that this form of euthanasia is an appropriate, humane response to terminal suffering in the last few days of life. Indeed, slow euthanasia may be a way for the physician to do what seems right for the dying in the absence of clear guidelines and supportive legislation for hastening death, perhaps analogous to the use of "slow codes" prior to the legalization of "no codes" and the assertion of patient rights to participate in decisions about cardiopulmonary resuscitation. However, since slow euthanasia is not fully recognized as

> euthanasia, it is not subject to appropriate oversight, including review by experts in symptom management and psychosocial care who can assure that appropriate comfort measures have been considered. Moreover, insofar as fully informed consent may not be obtained from the patient, this practice raises the specter of involuntary euthanasia.

Id.

C. ***Important interests, including respect for law and the rule of law, will suffer if this Court permits reinstatement of the irrational legislative regimes at issue here.***

Continued operation of the irrational State legislative regimes involved in these cases comes at great cost to important interests of individual citizens and to important interests of the States themselves.

First, there are the interests of patients, family members, and medical personnel who are forced to endure prolonged, unwanted, senseless, and cruel processes of dying for lack of the option of legalized physician-assisted suicide.

Second, are the interests of the vast number of patients who are put at risk of abuse created by a regime which does not take decisions to cause death by termination of care as seriously as it takes decisions to cause death by physician-assisted suicide.

Third, are the interests of the patients who are put at risk of abuse by a regime which permits illegal physician-assisted suicide to be widely practiced in secret without oversight or regulation.

Fourth, are the interests of those patients who are discriminated against by a regime which makes physician-assisted suicide available only to those who are well-enough connected to find a physician willing to provide such assistance despite the fact that it is illegal. In this respect, the situation is analogous to that which was eliminated by this Court in *Roe* v. *Wade*, 410 U.S. 113 (1973).

Fifth, are the interests of those physicians and other health care professionals who are made to feel insecure in the practice of medicine because of uncertainty as to which actions are in fact illegal and which are not. These individuals face the risk that their professional and personal lives may at anytime be destroyed by an unpredictable exercise of prosecutorial discretion.

Sixth, is the interest of the State in preserving respect for law and the rule of law. To the extent that the State appears to permit physicians to engage in illegal activity with impunity, it sends a message to society that citizens may pick and choose the laws that they must follow. At the very least, it tells physicians and the public as a whole that physicians are above the law. It establishes government by professional aristocracy rather than government by law.

Seventh, is the State's interest in the proper functioning of democratic processes. To the extent that the State permits wholesale violation of an unpopular law, it undercuts citizen incentives for repeal of the law. In this respect, the State legislative regimes involved in these cases are analogous to the Connecticut anti-contraception laws that were struck down in *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

Conclusion

For the reasons stated above, the decisions of the United States Courts of Appeal for the Second and Ninth Circuits should be affirmed.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

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Petitioners,

v.

HAROLD GLUCKSBERG, *et al.*,

Respondents.

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Respondents.

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BRIEF FOR RONALD DWORKIN, THOMAS NAGEL, ROBERT NOZICK, JOHN RAWLS, THOMAS SCANLON, AND JUDITH JARVIS THOMSON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE

Amici are six moral and political philosophers who differ on many issues of public morality and policy. They are united, however, in their conviction that respect for fundamental principles of liberty and justice, as well as for the American constitutional tradition, requires that the decisions of the Courts of Appeals be affirmed.[1]

[1] This brief is filed on the consent of all parties. *See* S. Ct. R. 37.3(a). It is not filed on behalf of any corporation. *See* S. Ct. R. 29.1.

INTRODUCTION AND SUMMARY OF ARGUMENT

These cases do not invite or require the Court to make moral, ethical or religious judgments about how people should approach or confront their death or about when it is ethically appropriate to hasten one's own death or to ask others for help in doing so. On the contrary, they ask the Court to recognize that individuals have a constitutionally protected interest in making those grave judgments for themselves, free from the imposition of any religious or philosophical orthodoxy by court or legislature. States have a constitutionally legitimate interest in protecting individuals from irrational, ill-informed, pressured or unstable decisions to hasten their own death. To that end, states may regulate and limit the assistance that doctors may give individuals who express a wish to die. But states may not deny people in the position of the patient-plaintiffs in these cases the opportunity to demonstrate, through whatever reasonable procedures the state might institute—even procedures that err on the side of caution—that their decision to die is indeed informed, stable, and fully free. Denying that opportunity to terminally-ill patients who are in agonizing pain or otherwise doomed to an existence they regard as intolerable could only be justified on the basis of a religious or ethical conviction about the value or meaning of life itself. Our Constitution forbids government to impose such convictions on its citizens.

Petitioners and the amici who support them offer two contradictory arguments. Some deny that the patient-plaintiffs have any constitutionally protected liberty interest in hastening their own deaths.[2] But that liberty interest flows directly from this Court's previous decisions. It flows

[2] *See, e.g.*, Brief for the Petitioners at 25-33, *Washington* v. *Glucksberg*; Brief for Petitioners Vacco and Pataki at 19-20, *Vacco* v. *Quill*; Brief Amici Curiae of the United States Catholic Conference, New York Catholic Conference, et al. in Support of Petitioners at 7-21, *Washington* v. *Glucksberg*; Brief for the Institute for Public Affairs of the Union of Orthodox Jewish Congregations of America and the Rabbinical Council of America as Amici Curiae in Support of Petitioners at 5-13, *Vacco* v. *Quill* and *Washington* v. *Glucksberg*.

from the right of people to make their own decisions about matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992).

The Solicitor General, urging reversal in support of Petitioners, recognizes that the patient-plaintiffs do have a constitutional liberty interest at stake in these cases. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 12, *Washington* v. *Vacco* [hereinafter Brief for the United States] ("The term 'liberty' in the Due Process Clause . . . is broad enough to encompass an interest on the part of terminally ill, mentally competent adults in obtaining relief from the kind of suffering experienced by the plaintiffs in this case, which includes not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily functions."); *see also id.* at 13 ("*Cruzan* . . . supports the conclusion that a liberty interest is at stake in this case."). The Solicitor General nevertheless argues that Washington and New York properly ignored this profound interest when they required the patient-plaintiffs to live on in circumstances they found intolerable. He argues that a state may simply declare that it is unable to devise a regulatory scheme that would adequately protect patients whose desire to die might be ill-informed or unstable or foolish or not fully free, and that a state may therefore fall back on a blanket prohibition. This Court has never accepted that patently dangerous rationale for denying protection altogether to a conceded fundamental constitutional interest. It would be a serious mistake to do so now. If that rationale were accepted, an interest acknowledged to be constitutionally protected would be rendered empty.

ARGUMENT

I. THE LIBERTY INTEREST ASSERTED HERE IS PROTECTED BY THE DUE PROCESS CLAUSE

The Due Process Clause of the Fourteenth Amendment protects the liberty interest asserted by the patient-plaintiffs here.

Certain decisions are momentous in their impact on the character of a person's life—decisions about religious faith, political and moral allegiance, marriage, procreation and death, for example. Such deeply personal decisions reflect controversial questions about how and why human life has value. In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience and convictions. This Court has insisted, in a variety of contexts and circumstances, that this great freedom is among those protected by the Due Process Clause as essential to a community of "ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937). In its recent decision in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992), the Court offered a paradigmatic statement of that principle:

> matters[] involving the most intimate and personal choices a person may make in a lifetime, choices central to a person's dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.

That declaration reflects an idea underlying many of our basic constitutional protections.[3] As the Court explained in

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[3] In *Cohen* v. *California*, 403 U.S. 15, 24 (1971), for example, this Court held that the First Amendment guarantee of free speech and expression derives from "the belief that no other approach would comport with the premise of individual dignity and choice upon which our political system rests." Interpreting the religion clauses of the First Amendment, this Court has explained that "[t]he victory for freedom of thought recorded in our Bill of Rights recognizes that in the domain of conscience

West Virginia State Board of Education v. *Barnette*, 319 U.S. 624, 642 (1943):

> If there is any fixed star in our constitutional constellation, it is that no official . . . can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.

A person's interest in following his own convictions at the end of life is so central a part of the more general right to

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there is a moral power higher than the State." *Girouard* v. *United States*, 328 U.S. 61, 68 (1946). And, in a number of Due Process cases, this Court has protected this conception of autonomy by carving out a sphere of personal family life that is immune from government intrusion. *See, e.g., Cleveland Bd. of Educ.* v. *LeFleur*, 414 U.S. 632, 639 (1974) ("This Court has long recognized that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment."); *Eisenstadt* v. *Baird*, 405 U.S. 438, 453 (1973) (recognizing right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear and beget a child"); *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942) (holding unconstitutional a state statute requiring the sterilization of individuals convicted of three offenses, in large part because the state's actions unwarrantedly intruded on marriage and procreation, "one of the basic civil rights of man"); *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967) (striking down the criminal prohibition of interracial marriages as an infringement of the right to marry and holding that "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men").

These decisions recognize as constitutionally immune from state intrusion that realm in which individuals make "intimate and personal" decisions that define the very character of their lives. *See* Charles Fried, *Right and Wrong* 146–47 (1978) ("What a person is, what he wants, the determination of his life plan, of his concept of the good, are the most intimate expressions of self-determination, and by asserting a person's responsibility for the results of this self-determination, we give substance to the concept of liberty.").

make "intimate and personal choices" for himself that a failure to protect that particular interest would undermine the general right altogether. Death is, for each of us, among the most significant events of life. As the Chief Justice said in *Cruzan* v. *Missouri*, 497 U.S. 261, 281 (1990), "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." Most of us see death—whatever we think will follow it—as the final act of life's drama, and we want that last act to reflect our own convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable moment.

Different people, of different religious and ethical beliefs, embrace very different convictions about which way of dying confirms and which contradicts the value of their lives. Some fight against death with every weapon their doctors can devise. Others will do nothing to hasten death even if they pray it will come soon. Still others, including the patient-plaintiffs in these cases, want to end their lives when they think that living on, in the only way they can, would disfigure rather than enhance the lives they had created. Some people make the latter choice not just to escape pain. Even if it were possible to eliminate all pain for a dying patient—and frequently that is not possible—that would not end or even much alleviate the anguish some would feel at remaining alive, but intubated, helpless and often sedated near oblivion.

None of these dramatically different attitudes about the meaning of death can be dismissed as irrational. None should be imposed, either by the pressure of doctors or relatives or by the fiat of government, on people who reject it. Just as it would be intolerable for government to dictate that doctors never be permitted to try to keep someone alive as long as possible, when that is what the patient wishes, so it is intolerable for government to dictate that doctors may never, under any circumstances, help someone to die who believes that further life means only degradation. The Constitution insists that people must be free to make these deeply personal decisions for themselves and must not be forced to end their lives in a way that appalls them, just because that is what some majority thinks proper.

II. THIS COURT'S DECISIONS IN *CASEY* AND *CRUZAN* COMPEL RECOGNITION OF A LIBERTY INTEREST HERE

A. *Casey* Supports the Liberty Interest Asserted Here

In *Casey*, this Court, in holding that a State cannot constitutionally proscribe abortion in all cases, reiterated that the Constitution protects a sphere of autonomy in which individuals must be permitted to make certain decisions for themselves. The Court began its analysis by pointing out that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." 505 U.S. at 851. Choices flowing out of these conceptions, on matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Id.* "Beliefs about these matters," the Court continued, "could not define the attributes of personhood were they formed under compulsion of the State." *Id.*

In language pertinent to the liberty interest asserted here, the Court explained why decisions about abortion fall within this category of "personal and intimate" decisions. A decision whether or not to have an abortion, "originat[ing] within the zone of conscience and belief," involves conduct in which "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Id.* at 852. As such, the decision necessarily involves the very "destiny of the woman" and is inevitably "shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Id.* Precisely because of these characteristics of the decision, "the State is [not] entitled to proscribe [abortion] in all instances." *Id.* Rather, to allow a total prohibition on abortion would be to permit a state to impose one conception of the meaning and value of human existence on all individuals. This the Constitution forbids.

The Solicitor General nevertheless argues that the right to abortion could be supported on grounds other than this

autonomy principle, grounds that would not apply here. He argues, for example, that the abortion right might flow from the great burden an unwanted child imposes on its mother's life. Brief for the United States at 14–15. But whether or not abortion rights could be defended on such grounds, they were not the grounds on which this Court in fact relied. To the contrary, the Court explained at length that the right flows from the constitutional protection accorded all individuals to "define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851.

The analysis in *Casey* compels the conclusion that the patient-plaintiffs have a liberty interest in this case that a state cannot burden with a blanket prohibition. Like a woman's decision whether to have an abortion, a decision to die involves one's very "destiny" and inevitably will be "shaped to a large extent on [one's] own conception of [one's] spiritual imperatives and [one's] place in society." *Id.* at 852. Just as a blanket prohibition on abortion would involve the improper imposition of one conception of the meaning and value of human existence on all individuals, so too would a blanket prohibition on assisted suicide. The liberty interest asserted here cannot be rejected without undermining the rationale of *Casey*. Indeed, the lower court opinions in the Washington case expressly recognized the parallel between the liberty interest in *Casey* and the interest asserted here. *See Compassion in Dying* v. *Washington*, 79 F.3d 790, 801 (9th Cir. 1996) (en banc) ("In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. *Casey* in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment."), *aff'g*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994) ("[T]he reasoning in *Casey* [is] highly instructive and almost prescriptive . . ."). This Court should do the same.

B. *Cruzan* Supports the Liberty Interest Asserted Here

We agree with the Solicitor General that this Court's decision in "*Cruzan* . . . supports the conclusion that a

liberty interest is at stake in this case." Brief for the United States at 8. Petitioners, however, insist that the present cases can be distinguished because the right at issue in *Cruzan* was limited to a right to reject an unwanted invasion of one's body. But this Court repeatedly has held that in appropriate circumstances a state may require individuals to accept unwanted invasions of the body. *See, e.g., Schmerber* v. *California*, 384 U.S. 757 (1966) (extraction of blood sample from individual suspected of driving while intoxicated, notwithstanding defendant's objection, does not violate privilege against self-incrimination or other constitutional rights); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905) (upholding compulsory vaccination for smallpox as reasonable regulation for protection of public health). The liberty interest at stake in *Cruzan* was a more profound one. If a competent patient has a constitutional right to refuse life-sustaining treatment, then, the Court implied, the state could not override that right. The regulations upheld in *Cruzan* were designed only to ensure that the individual's wishes were ascertained correctly. Thus, if *Cruzan* implies a right of competent patients to refuse life-sustaining treatment, that implication must be understood as resting not simply on a right to refuse bodily invasions but on the more profound right to refuse medical intervention when what is at stake is a momentous personal decision, such as the timing and manner of one's death. In her concurrence, Justice O'Connor expressly recognized that the right at issue involved a "deeply personal decision" that is "inextricably intertwined" with our notion of "self-determination." 497 U.S. at 287-89.

Cruzan also supports the proposition that a state may not burden a terminally ill patient's liberty interest in determining the time and manner of his death by prohibiting doctors from terminating life support. Seeking to distinguish *Cruzan*, Petitioners insist that a state may nevertheless burden that right in a different way by forbidding doctors to assist in the suicide of patients who are not on life-support machinery. They argue that doctors who remove life support are only allowing a natural process to end in death whereas doctors who prescribe lethal drugs are intervening to cause death. So, according to this argument, a state has an independent justification for forbidding doctors to assist in

suicide that it does not have for forbidding them to remove life support. In the former case though not the latter, it is said, the state forbids an act of killing that is morally much more problematic than merely letting a patient die.

This argument is based on a misunderstanding of the pertinent moral principles. It is certainly true that when a patient does not wish to die, different acts, each of which foreseeably results in his death, nevertheless have very different moral status. When several patients need organ transplants and organs are scarce, for example, it is morally permissible for a doctor to deny an organ to one patient, even though he will die without it, in order to give it to another. But it is certainly not permissible for a doctor to kill one patient in order to use his organs to save another. The morally significant difference between those two acts is *not*, however, that killing is a positive act and not providing an organ is a mere omission, or that killing someone is worse than merely allowing a "natural" process to result in death. It would be equally impermissible for a doctor to let an injured patient bleed to death, or to refuse antibiotics to a patient with pneumonia—in each case the doctor would have allowed death to result from a "natural" process—in order to make his organs available for transplant to others. A doctor violates his patient's rights regardless of whether the doctor acts or refrains from acting, against the patient's wishes, in a way that is designed to cause death.

When a competent patient does want to die, the moral situation is obviously different, because then it makes no sense to appeal to the patient's right not to be killed as a reason why an act designed to cause his death is impermissible. From the patient's point of view, there is no morally pertinent difference between a doctor's terminating treatment that keeps him alive, if that is what he wishes, and a doctor's helping him to end his own life by providing lethal pills he may take himself, when ready, if that is what he wishes—except that the latter may be quicker and more humane. Nor is that a pertinent difference from the doctor's point of view. If and when it is permissible for him to act with death in view, it does not matter which of those two means he and his patient choose. If it is permissible for a doctor deliberately to withdraw medical treatment in order to

allow death to result from a natural process, then it is equally permissible for him to help his patient hasten his own death more actively, if that is the patient's express wish.

It is true that some doctors asked to terminate life support are reluctant and do so only in deference to a patient's right to compel them to remove unwanted invasions of his body. But other doctors, who believe that their most fundamental professional duty is to act in the patient's interests and that, in certain circumstances, it is in their patient's best interests to die, participate willingly in such decisions: they terminate life support to cause death because they know that is what their patient wants. *Cruzan* implied that a state may not absolutely prohibit a doctor from deliberately causing death, at the patient's request, in that way and for that reason. If so, then a state may not prohibit doctors from deliberately using more direct and often more humane means to the same end when that is what a patient prefers. The fact that failing to provide life sustaining treatment may be regarded as "only letting nature take its course" is no more morally significant in this context, when the patient wishes to die, than in the other, when he wishes to live. Whether a doctor turns off a respirator in accordance with the patient's request or prescribes pills that a patient may take when he is ready to kill himself, the doctor acts with the same intention: to help the patient die.

The two situations do differ in one important respect. Since patients have a right not to have life support machinery attached to their bodies, they have, in principle, a right to compel its removal. But that is not true in the case of assisted suicide: patients in certain circumstances have a right that the state not forbid doctors to assist in their deaths, but they have no right to compel a doctor to assist them. The right in question, that is, is only a right to the help of a willing doctor.

III. STATE INTERESTS DO NOT JUSTIFY A CATEGORICAL PROHIBITION ON ALL ASSISTED SUICIDE

The Solicitor General concedes that "a competent, terminally ill adult has a constitutionally cognizable liberty

interest in avoiding the kind of suffering experienced by the plaintiffs in this case." Brief for the United States at 8. He agrees that this interest extends not only to avoiding pain, but to avoiding an existence the patient believes to be one of intolerable indignity or incapacity as well. *Id.* at 12. The Solicitor General argues, however, that states nevertheless have the right to "override" this liberty interest altogether, because a state could reasonably conclude that allowing doctors to assist in suicide, even under the most stringent regulations and procedures that could be devised, would unreasonably endanger the lives of a number of patients who might ask for death in circumstances when it is plainly not in their interests to die or when their consent has been improperly obtained.

This argument is unpersuasive, however, for at least three reasons. *First*, in *Cruzan*, this Court noted that its various decisions supported the recognition of a general liberty interest in refusing medical treatment, even when such refusal could result in death. 497 U.S. at 278-79. The various risks described by the Solicitor General apply equally to those situations. For instance, a patient kept alive only by an elaborate and disabling life support system might well become depressed, and doctors might be equally uncertain whether the depression is curable: such a patient might decide for death only because he has been advised that he will die soon anyway or that he will never live free of the burdensome apparatus, and either diagnosis might conceivably be mistaken. Relatives or doctors might subtly or crudely influence that decision, and state provision for the decision may (to the same degree in this case as if it allowed assisted suicide) be thought to encourage it.

Yet there has been no suggestion that states are incapable of addressing such dangers through regulation. In fact, quite the opposite is true. In *McKay* v. *Bergstedt*, 106 Nev. 808, 801 P.2d 617 (1990), for example, the Nevada Supreme Court held that "competent adult patients desiring to refuse or discontinue medical treatment" must be examined by two non-attending physicians to determine whether the patient is mentally competent, understands his prognosis and treatment options, and appears free of coercion or pressure in making his decision. *Id.* at 827-28, 801 P.2d at 630. *See also id.*

(in the case of terminally-ill patients with natural life expectancy of less than six months, patient's right of self-determination shall be deemed to prevail over state interests, whereas non-terminal patient's decision to terminate life-support systems must first be weighed against relevant state interests by trial judge); *In re Farrell*, 108 N.J. 335, 354, 529 A.2d 404, 413 (1987) (terminally-ill patient requesting termination of life-support must be determined to be competent and properly informed about prognosis, available treatment options and risks, and to have made decision voluntarily and without coercion). Those protocols served to guard against precisely the dangers that the Solicitor General raises. The case law contains no suggestion that such protocols are inevitably insufficient to prevent deaths that should have been prevented.

Indeed, the risks of mistake are overall greater in the case of terminating life support. *Cruzan* implied that a state must allow individuals to make such decisions through an advance directive stipulating either that life support be terminated (or not initiated) in described circumstances when the individual was no longer competent to make such a decision himself, or that a designated proxy be allowed to make that decision. All the risks just described are present when the decision is made through or pursuant to such an advance directive, and a grave further risk is added: that the directive, though still in force, no longer represents the wishes of the patient. The patient might have changed his mind before he became incompetent, though he did not change the directive, or his proxy may make a decision that the patient would not have made himself if still competent. In *Cruzan*, this Court held that a state may limit these risks through reasonable regulation. It did not hold—or even suggest—that a state may avoid them through a blanket prohibition that, in effect, the liberty interest altogether.

Second, nothing in the record supports the conclusion that no system of rules and regulations could adequately reduce the risk of mistake. As discussed above, the experience of states in adjudicating requests to have life-sustaining

treatment removed indicates the opposite.[4] The Solicitor General has provided no persuasive reason why the same sort of procedures could not be applied effectively in the case of a competent individual's request for physician-assisted suicide.

Indeed, several very detailed schemes for regulating physician-assisted suicide have been submitted to the voters of some states[5] and one has been enacted.[6] In addition,

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[4] When state protocols are observed, sometimes the patient is permitted to die and sometimes not. *See, e.g., In re Tavel*, 661 A.2d 1061 (Del. 1995) (affirming finding that petitioner-daughter had proven by clear and convincing evidence that incompetent patient would want life support systems removed); *In re Martin*, 450 Mich. 204, 538 N.W.2d 399 (1995) (holding that wife's testimony and affidavit did not constitute clear and convincing evidence of incompetent patient's pre-injury decision to decline life-sustaining medical treatment in patient's present circumstances); *DiGrella* v. *Elston*, 858 S.W.2d 698, 710 (Ky. 1993) ("If the attending physician, the hospital or nursing home ethics committee where the patient resides, and the legal guardian or next of kin all agree and document the patient's wishes and condition, and if no one disputes their decision, no court order is required to proceed to carry out [an incompetent] patient's wishes"); *Mack* v. *Mack*, 329 Md. 188, 618 A.2d 744 (1993) (holding that wife failed to provide clear and convincing evidence that incompetent husband would want life support removed); *In re Doe*, 411 Mass. 512, 583 N.E.2d 1263 (applying doctrine of substituted judgment and holding that evidence supported finding that, if incompetent patient were capable of making a choice, she would remove life support).

[5] For example, 46% of California voters supported Proposition 161, which would have legalized physician-assisted suicide, in November 1992. The measure was a proposed amendment to Cal. Penal Code § 401 (1992) which currently makes assisted suicide a felony. Those who did not vote for the measure cited mainly religious reasons or concerns that the proposed law was flawed because it lacked safeguards against abuse and needed more restrictions that might be easily added, such as a waiting period and a psychological examination. Alison C. Hall, *To Die With Dignity: Comparing Physician-Assisted Suicide in the United States, Japan, and the Netherlands*, 74 Wash. U. L. Q. 803, 817 n.84 (1996).

concerned groups, including a group of distinguished professors of law and other professionals, have drafted and defended such schemes. *See, e.g.*, Charles H. Baron, *et. al.*, *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. Legis. 1 (1996). Such draft statutes propose a variety of protections and review procedures designed to insure against mistakes, and neither Washington nor New York attempted to show that such schemes would be porous or ineffective. Nor does the Solicitor General's brief: it relies instead mainly on flat and conclusory statements. It cites a New York Task Force report, written before the proposals just described were drafted, whose findings have been widely disputed and were implicitly rejected in the opinion of the Second Circuit below. *See generally Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996). The weakness of the Solicitor General's argument is signalled by his strong reliance on the experience in the Netherlands which, in effect, allows assisted suicide pursuant to published guidelines. Brief for the United States at 23-24. The Dutch guidelines are more permissive than the proposed and model American statutes, however. The Solicitor General deems the Dutch practice of ending the lives of people like neo-nates who cannot consent particularly

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[6] In November 1994, Oregon voters approved the Oregon Death With Dignity Act through voter initiative, legalizing physician-assisted suicide under limited circumstances. Oregon Death With Dignity Act, Or. Rev. Stat. §§ 127.800-.827 (1995). Under the Oregon Act, a capable adult resident of the state, who

> has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his life in a human and dignified manner in accordance with [the provisions of the Act].

Or. Rev. Stat. § 127.805 (1995). The Act provides specific definitions of essential terms such as "incapable" and "terminal disease." The Act also provides numerous other regulations designed to safeguard the integrity of the process.

noteworthy, for example, but that practice could easily and effectively be made illegal by any state regulatory scheme without violating the Constitution.

The Solicitor General's argument would perhaps have more force if the question before the Court were simply whether a state has any rational basis for an absolute prohibition; if that were the question, then it might be enough to call attention to risks a state might well deem not worth running. But, as the Solicitor General concedes, the question here is a very different one: whether a state has interests sufficiently compelling to allow it to take the extraordinary step of altogether refusing the exercise of a liberty interest of constitutional dimension. In those circumstances, the burden is plainly on the state to demonstrate that the risk of mistakes is very high, and that no alternative to complete prohibition would adequately and effectively reduce those risks. Neither of the Petitioners has made such a showing.

Nor could they. The burden of proof on any state attempting to show this would be very high. Consider, for example, the burden a state would have to meet to show that it was entitled altogether to ban public speeches in favor of unpopular causes because it could not guarantee, either by regulations short of an outright ban or by increased police protection, that such speeches would not provoke a riot that would result in serious injury or death to an innocent party. Or that it was entitled to deny those accused of crime the procedural rights that the Constitution guarantees, such as the right to a jury trial, because the security risk those rights would impose on the community would be too great. One can posit extreme circumstances in which some such argument would succeed. *See, e.g.*, *Korematsu* v. *United States*, 323 U.S. 214 (1944) (permitting United States to detain individuals of Japanese ancestry during wartime). But these circumstances would be extreme indeed, and the *Korematsu* ruling has been widely and severely critized.

Third, it is doubtful whether the risks the Solicitor General cites are even of the right character to serve as justification for an absolute prohibition on the exercise of an important liberty interest. The risks fall into two groups. The first is

the risk of medical mistake, including a misdiagnosis of competence or terminal illness. To be sure, no scheme of regulation, no matter how rigorous, can altogether guarantee that medical mistakes will not be made. But the Constitution does not allow a state to deny patients a great variety of important choices, for which informed consent is properly deemed necessary, just because the information on which the consent is given may, in spite of the most strenuous efforts to avoid mistake, be wrong. Again, these identical risks are present in decisions to terminate life support, yet they do not justify an absolute prohibition on the exercise of the right.

The second group consists of risks that a patient will be unduly influenced by considerations that the state might deem it not in his best interests to be swayed by, for example, the feelings and views of close family members. Brief for the United States at 20. But what a patient regards as proper grounds for such a decision normally reflects exactly the judgments of personal ethics—of why his life is important and what affects its value—that patients have a crucial liberty interest in deciding for themselves. Even people who are dying have a right to hear and, if they wish, act on what others might wish to tell or suggest or even hint to them, and it would be dangerous to suppose that a state may prevent this on the ground that it knows better than its citizens when they should be moved by or yield to particular advice or suggestion in the exercise of their right to make fateful personal decisions for themselves. It is not a good reply that some people may not decide as they really wish—as they would decide, for example, if free from the "pressure" of others. That possibility could hardly justify the most serious pressure of all—the criminal law which tells them that they may not decide for death if they need the help of a doctor in dying, no matter how firmly they wish it.

There is a fundamental infirmity in the Solicitor General's argument. He asserts that a state may reasonably judge that the risk of "mistake" to some persons justifies a prohibition that not only risks but insures and even aims at what would undoubtedly be a vastly greater number of "mistakes" of the opposite kind—preventing many thousands of competent people who think that it disfigures their lives to continue living, in the only way left to them, from escaping that—to

them—terrible injury. A state grievously and irreversibly harms such people when it prohibits that escape. The Solicitor General's argument may seem plausible to those who do not agree that individuals are harmed by being forced to live on in pain and what they regard as indignity. But many other people plainly do think that such individuals are harmed, and a state may not take one side in that essentially ethical or religious controversy as its justification for denying a crucial liberty.

Of course, a state has important interests that justify regulating physician-assisted suicide. It may be legitimate for a state to deny an opportunity for assisted suicide when it acts in what it reasonably judges to be the best interests of the potential suicide, and when its judgment on that issue does not rest on contested judgments about "matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. A state might assert, for example, that people who are not terminally ill, but who have formed a desire to die, are, as a group, very likely later to be grateful if they are prevented from taking their own lives. It might then claim that it is legitimate, out of concern for such people, to deny any of them a doctor's assistance. This Court need not decide now the extent to which such paternalistic interests might override an individual's liberty interest. No one can plausibly claim, however—and it is noteworthy that neither Petitioners nor the Solicitor General does claim—that any such prohibition could serve the interests of any significant number of terminally ill patients. On the contrary, any paternalistic justification for an absolute prohibition of assistance to such patients would of necessity appeal to a widely contested religious or ethical conviction many of them, including the patient-plaintiffs, reject. Allowing *that* justification to prevail would vitiate the liberty interest.

Even in the case of terminally ill patients, a state has a right to take all reasonable measures to insure that a patient requesting such assistance has made an informed, competent, stable and uncoerced decision. It is plainly legitimate for a state to establish procedures through which professional and administrative judgments can be made about these matters,

and to forbid doctors to assist in suicide when its reasonable procedures have not been satisfied. States may be permitted considerable leeway in designing such procedures. They may be permitted, within reason, to err on what they take to be the side of caution. But they may not use the bare possibility of error as justification for refusing to establish any procedures at all and relying instead on a flat prohibition.

CONCLUSION

Each individual has a right to make the "most intimate and personal choices central to personal dignity and autonomy." That right encompasses the right to exercise some control over the time and manner of one's death.

The patient-plaintiffs in these cases were all mentally competent individuals in the final phase of terminal illness and died within months of filing their claims. Jane Doe described how her advanced cancer made even the most basic bodily functions such as swallowing, coughing, and yawning extremely painful and that it was "not possible for [her] to reduce [her] pain to an acceptable level of comfort and to retain an alert state." Faced with such circumstances, she sought to be able to "discuss freely with [her] treating physician [her] intention of hastening [her] death through the consumption of drugs prescribed for that purpose." *Quill* v. *Vacco*, 80 F.2d 716, 720 (2d Cir. 1996) (quoting declaration of Jane Doe). George A. Kingsley, in advanced stages of AIDS which included, among other hardships, the attachment of a tube to an artery in his chest which made even routine functions burdensome and the development of lesions on his brain, sought advice from his doctors regarding prescriptions which could hasten his impending death. *Id.* Jane Roe, suffering from cancer since 1988, had been almost completely bed-ridden since 1993 and experienced constant pain which could not be alleviated by medication. After undergoing counseling for herself and her family, she desired to hasten her death by taking prescription drugs. *Compassion in Dying* v. *Washington*, 850 F. Supp. 1454, 1456 (1994). John Doe, who had experienced numerous AIDS-related ailments since 1991, was "especially cognizant of the suffering imposed by a lingering terminal illness

because he was the primary caregiver for his long-term companion who died of AIDS" and sought prescription drugs from his physician to hasten his own death after entering the terminal phase of AIDS. *Id.* at 1456-57. James Poe suffered from emphysema which caused him "a constant sensation of suffocating" as well as a cardiac condition which caused severe leg pain. Connected to an oxygen tank at all times but unable to calm the panic reaction associated with his feeling of suffocation even with regular doses of morphine, Mr. Poe sought physician-assisted suicide. *Id.* at 1457.

A state may not deny the liberty claimed by the patient-plaintiffs in these cases without providing them an opportunity to demonstrate, in whatever way the state might reasonably think wise and necessary, that the conviction they expressed for an early death is competent, rational, informed, stable and uncoerced.

Affirming the decisions by the Courts of Appeals would establish nothing more than that there is such a constitutionally protected right in principle. It would establish only that some individuals, whose decisions for suicide plainly cannot be dismissed as irrational or foolish or premature, must be accorded a reasonable opportunity to show that their decision for death is informed and free. It is not necessary to decide precisely which patients are entitled to that opportunity. If, on the other hand, this Court reverses the decisions below, its decision could only be justified by the momentous proposition—a proposition flatly in conflict with the spirit and letter of the Court's past decisions—that an American citizen does not, after all, have the right, even in principle, to live and die in the light of his own religious and ethical beliefs, his own convictions about why his life is valuable and where its value lies.

Respectfully submitted,

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No. 95-1858 and No. 96-110

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—against—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents,

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, ATTORNEY GENERAL OF WASHINGTON,

Petitioners,

—against—

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, MD. PH.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

BRIEF OF *AMICUS CURIAE* BIOETHICISTS SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether physicians, following the scruples of their individual consciences, may ethically respect the competent, voluntary and informed requests of terminally-ill patients to be relieved from their pain and suffering by assisting them in hastening otherwise inevitable death?

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INTEREST OF THE AMICUS CURIAE

Bioethics, a learned discipline that arose approximately twenty-five years ago, deals "with ethical questions that arise as a result of advances in medicine and biology." OXFORD ENGLISH DICTIONARY (new ed.).

The bioethicists supporting Respondents in Vacco, et al. v. Quill, et al., No. 95-1858 ("Quill") and State of Washington v. Glucksberg, et al., No. 96-110 ("Glucksberg") are professors, lawyers, and medical doctors who have written and lectured extensively, and are considered among the nation's pre-eminent experts on the narrow issue before the Court.[1] Many of them hold multiple advanced degrees and occupy distinguished positions at universities and medical centers. They are identified at Appendix A.

The amicus group of bioethicists strongly believes that physicians, in carrying out their ethical duty to relieve the pain and suffering of their terminally-ill patients, should be legally permitted to accede to the desire of a patient to hasten death when the patient's decision is voluntarily reached, a patient is competent to make the decision, and the patient has been fully informed of the diagnosis and prognosis of an incurable, fatal disease which has progressed to the final stages. The amicus group also strongly believes that a physician may decline to honor such a request if it violates the physician's beliefs, morals or scruples or is contrary to the physician's medical judgment. The amicus group believes that the right to physician-assisted suicide should be recognized by this Court as a fundamental right, as the Court of Appeals for the Ninth

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[1] The bioethicists supporting Respondents have received the consent of the parties in Quill and Glucksberg to file this Amicus Curiae brief. The consents are being filed with the Court simultaneously with this brief.

Circuit ruled in Glucksberg. Moreover, the amicus group agrees with the Court of Appeals for the Second Circuit in Quill that the denial of physician-assisted suicide is a denial of equal protection to terminally-ill patients who do not have the option of hastening death by requesting the removal of life support systems.

These views are rooted in the four basic principles of biomedical ethics: autonomy, nonmaleficence, beneficence, and justice. Beauchamp and Childress, Principles of Biomedical Ethics (4th ed. 1994). From these principles, articulated in various ways in differing ethical systems, arise the two considerations most basic in medical care: the patient's fundamental right of self-determination and respect for the patient's interests. "Deciding To Forego Life-Sustaining Treatment," President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (March, 1983). Ethical requirements of respect for the patient's right of self-determination and respect for the patient's interests appropriately guide all care of patients, including the care of dying patients. Dan W. Brock, "Voluntary Active Euthanasia," Hastings Center Report 22:2 (March-April 1992) 10-22.

ARGUMENT

THIS COURT SHOULD RECOGNIZE A RIGHT TO PHYSICIAN-ASSISTED SUICIDE FOR COMPETENT DYING PATIENTS

Petitioners and their supporting amici have presented arguments that far exceed the understanding of physician-assisted suicide as approved by the Second and Ninth Circuit Courts. They argue that permitting physician-assisted suicide for terminally ill patients who seek to end their suffering in the final stages of degenerative diseases will lead to the involuntary killing of terminal patients and the healthy mentally ill and disabled.

These arguments are entirely flawed. The institution of safeguards to prevent abuse is necessary, but there is no basis to conclude that a voluntary practice limited to terminally-ill patients would be involuntarily applied, or that it could be imposed upon incompetents.

Petitioners and their amici also attempt to exploit taboos associated with suicide, citing, for example, instances of suicide among the depressed or mentally ill. The cases before this Court, however, do not involve sanctioning suicide of depressed or mentally-ill individuals.

Unlike other cultures, our language has but one word to describe self-inflicted death. The word "suicide" does not differentiate among the deaths of a teenager overcome by the struggles of adolescence, a middle-aged family man facing financial ruin and an eighty-year old cancer patient who seeks to avoid further protracted pain and suffering when her death is near. Unlike the first two tragic illustrations, there can be a sense of meaningfulness, emotional resolution, and communicative culmination, including gratitude for a life now complete, in the "suicide" of the dying patient who seeks both to avoid a bad death and to bring life to an inevitable but appropriate close. The dying patient may act to avoid or relieve suffering, and may also seek to meet death at a time and place of his or her own choosing, surrounded by those whom he or she trusts and loves, while still conscious and still capable of prayer and farewells. The right to seek a death which is both free of pain, but faced while conscious and alert, is not a trivial right, but one of great significance for many people.

The common term "suicide" carries strongly negative associations that have no bearing on the issue before the Court, but are largely derived from medieval attitudes towards violent self-destruction. Battin, The Death Debate: Ethical Issues in Suicide (1996). It would have been more accurate if the debate on

this issue had been joined on physician-assisted "death" as distinct from physician-assisted "suicide."

The Prevalence Of Death From Degenerative Disease Is A Modern Problem Not Addressed By Antiquated Laws

Petitioners stress the long tradition of prohibition against suicide, including penal laws dating to the founding of this country. But such laws derive from a time when death was rarely preceded by long periods of physiologically degenerative suffering. At the time the Constitution and the Bill of Rights were written and throughout the development of English common law, the process of dying was usually quick and more likely to be due to infectious disease. Medical intervention did little to prolong life, or to prolong the process of dying. The cases before the Court, however, involve degenerative death, a creature of modern medicine; they should therefore be decided on an historically clean slate. The Court, in finding for Respondents, would not be judicially mandating social change; it would be applying constitutional doctrines of protected individual rights to a new factual situation.

Epidemiologists identify four distinct periods to describe mortality and longevity in the history of mankind. In the Age of Pestilence and Famine, which extended from the dawn of human existence to approximately 1850, people died primarily from infectious and parasitic diseases, frequently exacerbated by famines and plagues. Advances in public sanitation, immunization and antisepsis in medicine gave rise to the Age of Receding Pandemics, which lasted until approximately 1920 and was accompanied by an increase in life expectancy. In the period from 1920 until 1960, the Age of Degenerative Man-Made Diseases, advanced surgical techniques, antibiotics, techniques for the administration of intravenous fluids and drugs, the development of respiratory support systems and improved therapeutic and diagnostic techniques further increased life expectancy. Omran, "The Epidemiologic Transition:

A Theory of the Epidemiology of Population Change," Milbank Memorial Fund Quarterly 49 (4):509-38 (1971). Epidemiologists characterize the current state of mortality and life expectancy, which arose in the mid 1960's, as the Age of Delayed Degenerative Diseases, in which the majority of people die at later ages from degenerative diseases, such as cancer, heart disease, stroke and neurological diseases. Olshansky and Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," in Timothy M. Smeeding, et al., eds. Should Medical Care Be Rationed By Age? (1987) 11-43.

These epidemiological changes are partly illustrated by the changes in life expectancy. At the turn of this century, American life expectancy at birth was 46.5 years for males and 49 years for females. Life expectancy at birth is now approximately 72 years for males and 79 years for females. Life Tables for the United States 1900-2050, Social SecurityAdministration, SSA Pub. No. 11-11534. But these advances in life expectancy are associated with a fundamental change in the way we die: throughout the developed world of the late 20th century, including the United States, the majority of the population will die of degenerative disease. About a third of deaths are due to circulatory disease; another third are due to cancer; and the remaining third include degenerative conditions like neurological diseases and various forms of organ failure. The modern form of degenerative death is estimated to account for 70-80% of all deaths in the United States. Battin, The Death Debate, at 178.

Not only do these deaths from degenerative disease tend to occur at more advanced ages than has been characteristic of earlier periods of human mortality, but particularly in the case of cancer, they are often accompanied by protracted periods of pain and suffering before death, a phenomenon which occurred comparatively rarely until recent years. Prior to the development of modern antibiotics, the patient whose condition deteriorated severely or who became bedridden was likely to contract pneumonia

or other infections and die, thus being naturally spared the most difficult phases of end-stage disease.

The issue of physician-assisted suicide should be decided on the basis of present realities and not by reference to antiquated laws and customs adopted long before the modern form of degenerative death became prevalent. Neither the framers of the Constitution, nor any previous legal authorities, could have foreseen the way most people now die.

Classical Medicine Recognized A Patient's Right To Physician-Assisted Suicide

In Quill, petitioners cite one version of the Hippocratic Oath which contained the prohibition: "To please no one will I prescribe a deadly drug, nor give advice which may cause his death." Petitioners seem to suggest that the Oath has the force of law, but the version they cite also prohibits a number of medical practices clearly and uncontroversially recognized as legal, including surgery and charging fees for teaching medicine, as well as practices explicitly recognized as legal by this Court, such as abortion.

The Hippocratic Oath can only be understood in its historical context. At the time of Hippocrates, there was no prohibition against physician-assisted suicide in mainstream Greek medicine; the practice was subject to consultation and informed consent similar in intent to the protocols urged by medical professionals and bioethicists today. Thus, at the time of Hippocrates:

> ...the taking of poison was the most usual means of committing suicide [in terminal illness], and the patient was likely to demand the poison from his physician who was in possession of deadly drugs and knew that which brought about an easy and painless death. On the other hand, such a resolution was not taken without due deliberation, except perhaps in a few cases of great distress or mental strain. The sick man wished to be sure that further treatment would be of no avail, and to render this verdict was the physician's task. The patient, therefore, consulted with him, or urged his friends to speak to the doctor. If the latter, in such a consultation, confirmed the seriousness or hopelessness of the case, he suggested directly or indirectly that the patient commit suicide.... [I]n antiquity many physicians actually gave the patients the poisons for which they were asked.

Ancient Medicine: Selected Papers of Ludwig Edelstein, Owsei and C. Lillian Temkin, eds. (1967) 11-13. See also, Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots," Hastings Center Report (August 1978) 23, 26-27 (Hippocratic Oath is an "esoteric document that is often inconsistent with the larger picture of Greco-Roman medical ethics."); Gourevitch, "Suicide Among the Sick in Classical Antiquity," Bulletin of the History of Medicine 43 (1969) 501, 506-08.

Adherents of the Hippocratic school of medicine were strongly influenced by Pythagoras. Not unlike contemporary adherents of natural cures for disease, he eschewed many then-mainstream, accepted medical practices. The original Greek version of the Oath, quoted by the Quill petitioners, required the followers of Hippocrates:

> to teach them this art--if they desire to learn it -- without fee and covenant;
>
> * * *
>
> [to] apply dietetic measures for the benefit of the

sick according to my ability and judgment;

* * *

not [to] give to a woman an abortive remedy

* * *

not [to] use the knife....

Ancient Medicine at 6.

The text of the Hippocratic Oath has been modified many times through the ages. Contemporary versions, routinely adopted in medical-school graduation exercises and similar contexts (see text of Oath adopted by World Medical Association in 1948 reproduced at Appendix B), do not contain the prohibitions against surgery, abortion, or accepting fees for teaching medicine, and also omit the prohibition against physician-assisted suicide. In short, neither the Hippocratic Oath nor classical tradition provides a compelling ethical or professional prohibition of physician-assisted suicide.

Petitioners Have Not Advanced Sufficient Interests To Overcome The Right Of A Terminally-Ill Patient To Assisted Death

The States of New York and Washington argue that the government has an overriding interest in the preservation of life which is not subject to veto by the individual wishes of dying patients. Similarly, the American Medical Association and other amici supporting Petitioners contend that physicians are devoted to the healing arts and should not be involved in the termination of life.

Not only is there no adequate basis for either of these claims, but the AMA's position does not even reflect the views or practices of its constituency. In fact, physicians are divided about this issue, and many support the recognition of a patient's right to assistance and reject state interference in their right to practice medicine in a way they see as humane, compassionate, and respectful of the wishes of their dying patients. As reported in The New England Journal of Medicine, 60 percent of doctors in Michigan and 66 percent of doctors in Oregon -- two states in which this issue has been very widely discussed -- support legalizing assisted suicide for terminally-ill patients. Lee, et al., "Legalizing Assisted Suicide -- Views of Physicians in Oregon," New England Journal of Medicine 335:5 (Feb. 1, 1996) 310-315, at 311; Bachman, et al., "Attitudes of Michigan Physicians and of the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," New England Journal of Medicine, 334:5 (Feb. 1, 1996) 303-309, at 303. In the State of Washington, 12 percent of physicians polled reported that they had been asked by their terminally-ill patients for prescriptions to hasten death, and of these, 24 percent had complied with such a request in the year prior to the study. Bach, et al., "Physician Assisted Suicide and Euthanasia in Washington State," Journal of the American Medical Association 275:12 (March 27, 1996) 919-925 at 919.

Assertions that doctors should have no role in death fly in the face of reality. All people eventually die, and the doctor's role appropriately includes ensuring that the patient's death occurs as humanely as possible. As Francis Bacon wrote, the physician's role is to help the patient "make a faire and easie passage."

The humaneness of a death is not only a matter of avoiding pain and physical suffering; it is also a matter of consonance with a patient's most basic values. For some patients, a death softened by the heavy use of painkillers or hastened by withholding or withdrawing life-sustaining treatment will be tolerable; for others such prospects are profoundly repugnant: these patients fear and

resent a death preceded by a period of obtundation, or in which their bodies slowly deteriorate from the ravages of a lethal disease. Not all patients will choose to die in the same way, even when death is imminent: some will prefer continued aggressive treatment, in the hope that they can beat the odds; some will prefer withdrawing or withholding specific forms of treatment; others will accept death as a consequence of escalating doses of morphine; still others will choose to forego nutrition and hydration; some will tolerate terminal sedation; but some strongly prefer a peaceful and humane death directly initiated while conscious and alert, facilitated by the assistance of a physician.

Physician-assisted suicide is not an option likely to be chosen by many. In the Netherlands, where assistance in dying is openly practiced and widely accepted, less than 3.5% of patients dying in a given year chose this manner of death. Yet it can be of very great moral and spiritual importance to those who make this choice. It may be the privilege of religious traditions to reject such a practice, as several of the Petitioners' amici point out, but it is not their privilege to assert that such an act on the part of a dying patient must be devoid of personal or spiritual significance.

Petitioners and their amici repeatedly assert the state's interest in preservation of life. This interest, however, is necessarily subject to careful qualification. Washington and New York have capital punishment statutes, permitting state-sanctioned death of otherwise healthy individuals. Revised Code of Washington 9A.32.030; New York Penal Law Section 60.06. The state, in times of war, sacrifices the lives of its most vital citizens to the national interest. Because the state approves of the deaths of individuals when it serves its interests, the state cannot advance an absolute objection to participation in death as an answer to claims that terminally ill patients have a right to seek and accept assistance from their physicians in suicide. The state clearly does have an interest in preventing suicide that is impulsive, aggressive, irrational, violent, or coerced, or where the suicidal impulse arises

from depression or other mental illness; but the state does not have an interest in preventing a competent patient, who is in any case facing death, from rationally and reflectively choosing what to that person is the preferable way of meeting death. It is the overly broad, unwarrantedly negative connotations of the term "suicide" that obscure this crucial distinction.

Virtually all data about the causes and characteristics of suicide and its relationship to mental illness, cited by several of Petitioners' amici, is data only about suicides in the former sense. Although rational, reflective suicides do occur in terminal illness, often assisted by physicians, they are virtually never reported as suicides, and it has thus been impossible to collect reliable data about these latter "suicides." Suicide is often said to be about the choice between life and death. Glucksberg and Quill, however, are not cases about patients choosing between life and death. They are about patients choosing death in a way that seems to them dignified, humane and more in keeping with their basic values, rather than what seems to them a less desirable and undignified death.

In a lengthy footnote, the Bioethics Professors' Amicus Curiae Brief Supporting Petitioners argues that physicians have no fear of prosecution if they prescribe drugs which a patient subsequently uses to commit suicide, provided the physician is not present when the patient takes the lethal medication. Brief For Bioethics Professors Amicus Curiae Supporting Petitioners at 15-16 n. 6.[2] Even if that were the case, maintaining such a status quo

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[2] We too, believe that this act should not be regarded as a criminal one, provided the prescription is provided at the voluntary request of a competent, fully informed patient. We particularly welcome these bioethicists' tacit recognition that some dying patients will prefer a directly-caused death and that some physicians will be willing to provide the means for it, since it counters the quite trivializing claim from other amici that the use of opiates, of

would be unsatisfactory. Physicians do not generally believe that they would be free from prosecution and they are often relunctant to assist patients who wish to die with dignity; it is at best a legally controversial claim. Because current statutes criminalizing assisted suicide contain no exemption for physicians, doctors are often constrained to abandon their patients at their time of greatest need. Even when a doctor prescribes the necessary drugs he or she often refuses to assist the patient in using the drugs. Unaided by professional assistance, an already suffering patient in the process of dying may take the medication improperly, survive, and undergo still more substantial suffering from unwanted, sublethal complications. Lonny Shavelson, A Chosen Death: The Dying Confront Assisted Suicide, (1995).; Stephen Jamison, Final Acts of Love: Families, Friends, and Assisted Dying (1995). Such profoundly unwanted events are not uncommon among "amateur" assisted suicides.

The bioethics professors supporting Petitioners erroneously believe that medical ethics is advanced by a practice where a physician and patient are encouraged to conspire covertly to circumvent the law, but where the patient is then denied medical assistance at the time of death and left to suffer the consequences of inadequate procedures. The bioethicists who are signators of the present brief believe strongly that medical ethics and trust in physicians are better served by physician-assisted suicide where the patient can have the care, comfort and treatment of his or her doctor at the time the patient acts to hasten death.

The argument of the Bioethics Professors in Support of Petitioners also misinterprets the medical facts of dying. Their brief, addressing the equal protection argument in Quill, attempts

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discontinuing life sustaining treatment, of withholding nutrition and hydration, and of terminal sedation are sufficient answers to the patient's distress.

to differentiate between patients on life support and those who are not. Those on life support are different, they argue, because of a bodily intrusion that could only have taken place with their consent, which consent they can withdraw at any time. They further claim that a terminally-ill person who is not on life support is differently situated for equal protection analysis because he or she is not being subjected to an ongoing physical intrusion. But this argument is erroneous. Both types of patients have had bodily intrusions for which they have given consent. A patient gives consent for a ventilator, or a feeding tube, and can then withdraw that consent and the bodily intrusion. Another patient gives consent for chemotherapy, a bodily intrusion which changes him or her unalterably, and ultimately leaves the patient in a condition of dying quite differently from that without the chemotherapy; yet the patient cannot withdraw that bodily intrusion, since it has already irreversibly occurred. Patients not connected to life support are therefore not free from bodily intrusion, and patients who are connected to life support do not die "naturally" if that support is removed. Once life has been prolonged with any sort of therapy, the mode of dying is unnatural; irreversible physical intrusion has already occurred. The Second Circuit Court of Appeals correctly rejected the claim that there is a rational distinction between refusing treatment and suicide.

Protocols and Guidelines
May Be Imposed To
Avoid The "Slippery Slope"

This Court has recognized the rights of individuals to make major life decisions regarding the integrity of their bodies, Roe v. Wade, 410 U.S.113 (1973); Planned Parenthood of Southeastern Pennsylvania v. Casey, 502 U.S. 1056 (1992), including the right of the terminally-ill to determine the end of their lives. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990). In all of these cases, the Court has carefully delineated the rights in question and stated that they are subject to reasonable regulation.

Roe v. Wade, supra, 410 U. S. at 163 ("a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."); Planned Parenthood v. Casey, supra, 505 U.S. at 872 ("Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not follow at all that the State is prohibited from taking steps to ensure that the choice is thoughtful and informed"); Cruzan, supra, 497 U.S. at. 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.").

Despite the history of caution by this Court in delineating rights with respect to life and death decisions, Petitioners and their amici contend that the Court's recognition of a right of competent, terminally-ill patients to obtain physician-assisted suicide will lead down a slippery slope such that its holding will lead to involuntary deaths or physician-facilitated deaths of the incompetent.

There is no basis to believe that physician-assisted suicide will lead to such abuses. Safeguards would obviously be devised to protect against abuse. Examples of such safeguards, the details of which are the appropriate concern of the states in regulating the exercise of patients' constitutionally-protected basic rights, are available both in this country and abroad. For example, the Oregon Death With Dignity Act, which by its terms is limited to competent adults who have been determined by the attending physician to be suffering from a terminal disease, requires two oral and one written request from the patient witnessed by two individuals to the effect that the patient is competent, acting voluntarily and is not being coerced to sign the request; requires the physician to inform the patient of his or her medical diagnosis and prognosis, the potential risks in, and probable results from, taking the medication; requires that the physician inform the patient of the feasible alternatives, including comfort care, hospice care, and pain control, requires that

the patient be referred to a consulting physician for confirmation of the diagnosis and determination that the patient is competent and acting voluntarily; requires that the patient be referred for counseling if appropriate; imposes a fifteen-day waiting period; and requires that the attending physician provide full documentation demonstrating compliance with the Act. It permits the patient to rescind the request at any time, in any manner.

Similarly, the Dutch guidelines for physician-assisted suicide require that the patient make a voluntary, enduring request; that the patient have adequate information about his or her disease, including alternative methods of treatment; that the patient's suffering be intolerable, in the patient's view, and irreversible, without alternatives for relieving the suffering that are acceptable to the patient; that the attending physician exercise due care in reviewing and verifying the patient's condition; that there be a consultation with a second, independent physician; and that the physician who provides assistance in hastening death file a written report of the death, which may not be reported as a natural death. Battin, The Least Worst Death (1994) at 131. Angel, "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996) 1676.

We believe such safeguards will provide patients clearly adequate protection against pursuing physician-assisted suicide from impulse, irrationality, depression, misinformation, manipulation, or coercion. They constitute reasonable means of assuring voluntary choice, of ruling out mental illness, of preventing mistaken diagnoses or faulty prognostications of terminal illness, of detecting familial, professional, or institutional pressures on the patient, of assuring that the practice actually serves the patient's interests, of protecting against the devaluation of members of minorities or disabled or medically dependent people, or in other ways protecting the patient's basic rights. Abuses are equally possible when treatment is withheld or withdrawn, when dosages of painkillers are used which foreseeably

depress respiration and so hasten death, when nutrition and hydration are withdrawn, when do-not-resuscitate orders are written, and when other commonplace strategies of "negotiated" death are employed. While there is no credible evidence that these possible abuses are in fact occurring to any significant degree, the safeguards to be erected for the protection of patients in the matter of physician-assisted suicide should operate to provide greater assurance of full voluntariness and full information, and, by requiring reporting, would allow surveillance of the practice to discover and penalize physicians or others who do not adhere to regulatory restrictions. Battin, "Voluntary Euthanasia and the Risks of Abuse," in Battin, The Least Worst Death, 163-181.

Petitioners and their amici claim that the experience of the Netherlands in permitting physician-performed euthanasia and physician-assisted suicide shows the substantial risks of a "slippery slope," where legalization or legal toleration of directly caused death leads to widespread unacceptable killing. Many of their claims are empirically false and grossly distorted. There is no evidence of conscious, competent patients being euthanasized against their will.[3]

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[3] In the majority of cases, a patient's current, explicit request, fitting the guidelines cited above, is in force at the time of assistance in suicide or euthanasia. In a fraction of cases (0.7%), there is no current explicit request; in about half of these cases (including all competent patients), either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable. In the other cases the patient was incompetent. In 91% of these cases, life was shortened by a week or less (in a third, 24 hours or less), and in the small number with longer life expectancy, the patient was evidently suffering greatly but verbal contact was no longer possible. Van der Maas et al., "Euthanasia, Physician-Assisted

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Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1699, 1701-1702. Loes Pijnenborg et al.,"Life-Terminating Acts Without Explicit Request of Patient," The Lancet 341 (May 8, 1993) 1196-1199.

New evidence from the Netherlands, based on studies which repeated the initial empirical studies of euthanasia and physician-assisted suicide known as the Remmelink report, show that reporting has increased and the frequency of cases regarded as problematic has decreased. The number of cases has increased in association with the aging of the population and an increase in the proportion of deaths from cancer, a function of the decrease in deaths from ischemic heart disease, but the proportion of requests granted has decreased. (Indeed, most requests for euthanasia or assistance in suicide are not granted.) Physician-assisted death does not involve patients whose illnesses are less severe, nor are there any signs that the decisionmaking has become less careful -- rather, there is more frequent consultation and better documentation. Van der Maas, supra, at 1703, 1705; Gerrit van der Wal et al., "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1706-1711.

In the view of the researchers, "these data do not support the idea that physicians in the Netherlands are moving down a slippery slope," Van der Maas, supra, at 1705, a view echoed by the Executive Editor of the New England Journal of Medicine. Marcia Angel, MD., Editorial: "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996), 1676-1678, at 1677. Physician-assisted death continues to account for less than 3.5% of all reported deaths: thus the vast majority of patients dying in a given year do not choose it, and even the vast majority of cancer patients -- the most frequent

The Right of Competent, Dying Patients to Physician-Assisted Suicide is a Negative Right To Be Free from State Interference

In Glucksberg, the Ninth Circuit Court of Appeals held that physician-assisted suicide is a fundamental liberty right. This right to determine one's own mortality shares one important characteristic with other fundamental rights. Like the rights to vote or to worship, there is no requirement that the right be exercised. Joel Feinberg, "Voluntary Euthanasia and the Inalienable Right to Life," Philosophy and Public Affairs 7, no. 2 (Winter, 1978).

Similarly, under neither Glucksberg nor Quill would a physician be required to accede to a request for suicide assistance if the request violates the doctor's personal, medical or religious beliefs. The constitutionally-protected right asserted in these cases is, as bioethicists would put it, a negative right, a right not to be interfered with, a true liberty-right. Neither case asserts a positive right or claim-right, a demand that patients could make upon physicians whether physicians felt it medically or morally appropriate to respond or not. Thus, the full and appropriate scope of a physician's rights as well as a patient's rights would be recognized, since the physician would no longer be legally constricted in caring for a terminally-ill patient where that patient sought help in hastening death, though he or she would not acquire any new or unwanted obligation, and the full range of a patient's traditional, constitutionally-protected liberty rights of self-determination would be recognized in the new factual circumstance of the modern form of degenerative death.

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diagnosis – do not. Yet it remains widely regarded as an important option even if one rarely needed or utilized.

Recognition of a protected right to seek and accept assistance in suicide from a willing physician is not only important for the comparatively small number of terminally-ill patients who might actually use it. Those patients who do not choose to exercise their right to physician-assisted suicide may gain comfort in the knowledge that the option exists if their suffering becomes intolerable. For many, this will make it possible to live fuller, more complete, lives during the process of dying, since they need not fear a bad death. Timothy E. Quill, M.D. "Death and Dignity: A Case of Individualized Decision Making." The New England Journal of Medicine 324:10 (March 7, 1991), 691-694. Indeed, the possibility of physician-assisted suicide, even if never used, may contribute positively to the quality of life for those facing death.[4]

The records before this Court contain the testaments of the individual, suffering plaintiff-patients -- all of whom died without the desired assistance of their physicians in terminating their pain and suffering and without the knowledge that the Courts of the Ninth and Second Circuits would respond to their anguished pleas. Their tales of agony could be reiterated many thousand times over, but may be summarized by the final note of the Nobel Prize-winning physicist, Percy Bridgman, who nearly 80 years old and suffering from terminal cancer, shot himself. His note stated:

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[4] A 1994 Australian study of cancer patients found that those who anticipated a role for the more active options of suicide and/or euthanasia in their own futures, compared to those who anticipated a future possible role for only the more passive options of wishing death to come early or ceasing all treatment, were more hopeful and reported a higher quality of life than patients who regarded them as out of the question. Owen, et al., "Cancer Patient's Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia," Psycho-Oncology 3:1-9 (1994).

> It isn't decent for society to make a man do this thing himself. Probably this is the last day I will be able to do it myself.

Percy Bridgman, letter in Bulletin of the Atomic Scientists, quoted by Max Delbruck, "Education for Suicide," interview in Prism, a publication of the American Medical Association, 2 (1974) 20.

CONCLUSION

Affirmation of the decisions below will contribute to a more decent society, more respectful of patients' basic rights and interests in the light of the realities of the modern form of degenerative death. We strongly urge that they be affirmed.

Dated: New York, New York
December 9, 1996

Respectfully submitted,

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APPENDIX A

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APPENDIX B

THE OATH OF HIPPOCRATES

I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration.

I will hold in confidence all that my patient confides in me. I will maintain the honor and the noble traditions of the medical profession.

My colleagues will be as my family. I will not permit considerations of race, religion, nationality, party politics, or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life.

Even under threat I will not use my knowledge contrary to the laws of humanity. These promises I make freely and upon my honor.

Approved by the World Medicine Association in 1948.

(52) (5D)

Nos. 95-1858 and 96-110

Supreme Court U.S.
DEC 10 1996
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON; CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., AND PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals and for the Second Circuit and for the Ninth Circuit

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BRIEF OF THE COALITION OF HOSPICE PROFESSIONALS AS AMICUS CURIAE FOR AFFIRMANCE OF THE JUDGMENTS BELOW

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INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, a coalition of medical professionals who have extensive experience in providing hospice and palliative care to terminally-ill patients (the "Coalition") respectfully submits this brief in support of the Respondents.[1] All parties have consented to the filing of this brief, and the letters so stating have been filed with the Court.

Hospice and palliative care professionals participate in a system of care which employs an interdisciplinary team of physicians, nurses, home health aides, ethicists, chaplains, and bereavement counselors providing physical, emotional and spiritual support to people at the end of life. Hospice care does not involve medical interventions intended to defer death. Rather, the professionals, patients and their families treat death as an accepted part of life's continuum, and they work together to lend comfort, dignity and meaning to this final stage. In serving patients' goals and enhancing patients' ability to direct their lives, a principal role for the Coalition's members is providing relief from suffering. For many terminally-ill patients, suffering encompasses debilitating physical distress and psychological agony arising out of the loss of self-defined dignity, and living in conflict with spiritual and philosophical beliefs.

The Coalition believes that physician-assisted suicide must be an option of last resort and then only at the request of the terminally-ill patient. However, terminal illness alone does not justify choosing to hasten death. Aggressive hospice and palliative care -- also known as comfort care -- is highly effective for many patients. The medical profession and policymakers should enhance the availability of comfort care and establish it as

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[1] Appended to this brief is a list of the Coalition's members including their credentials and professional affiliations. The members of the Coalition speak from their collective personal experiences in the daily care of severely-ill and terminally-ill patients and do not speak for the institutions with which they are affiliated.

the standard of care for dying patients. However, hospice and palliative care does not always relieve suffering. For some patients, the pain can be so overwhelming that they cannot focus on anything beyond their unremitting suffering, and "life" becomes nothing more than their pain. Other patients appear to attain relief only with sedation so heavy that they cannot function, cannot interact with anyone, and "life" consists merely of lying inert, a condition that those patients reject as intolerable. The Coalition's members have treated patients whose distressing physical symptoms were too severe to be managed and have observed such patients wishing to hasten death. The Coalition believes that those desires can be fully competent and rational choices.

The legal availability of physician-assisted suicide in no way displaces the primacy and effectiveness of hospice and palliative care. As professionals, the Coalition's members intend to continue to respect the wishes of terminally-ill patients and to provide the best palliative care to each of them, including those who might choose a hastened death. Hospice and palliative care providers are particularly expert in determining whether a patient has explored all appropriate palliative treatments and whether the patient requests hastened death because of inadequate efforts to relieve suffering. Indeed, removing legal bans on suicide assistance will enhance the opportunity for advanced hospice care for all patients because regulation of physician-assisted suicide would mandate that all palliative measures be exhausted as a condition precedent to assisted suicide.

The Coalition attends to the physical, emotional and spiritual needs of terminally-ill patients and their families on a daily basis, and therefore is highly qualified to advocate on their behalf. As distinguished professionals in the fields of hospice and palliative care, the Coalition's members have a vital interest in presenting their terminally-ill patients with the broadest range of medical

options to alleviate suffering and promote dignified and meaningful living. These options must include, as a last resort for patients who judge their own suffering unendurable, prescribing medication that will enable those patients to hasten their own imminent deaths. These essential goals will be seriously undermined if this Court reverses the decisions of the Courts of Appeal for the Second and Ninth Circuits.

INTRODUCTION AND SUMMARY OF ARGUMENT

Both the Second and Ninth Circuits have struck down statutes that made it a crime to assist a person in committing suicide, as applied to physician-assisted suicide.[2] While the Second and Ninth Circuits adopted differing jurisprudential frameworks in reaching their conclusions, both courts examined, analyzed and balanced the respective interests of the individual and the State, but ultimately were not persuaded by the legitimacy and/or weight of the State's proffered justifications for the statutes. *See Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (holding that a New York statute criminalizing suicide

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[2] The terms "physician-assisted suicide," "assisted suicide," and "assisted death" are used interchangeably to refer to the practice in which a physician prescribes a lethal drug but the drug is actually administered by the terminally-ill patient. *See Compassion In Dying v. Washington*, 79 F.3d 790, 802 n.15 (9th Cir. 1996). Terms such as "physician-aid-in dying" or "euthanasia" refer to other medical actions which proximately bring about the death of a patient. Physician-assisted suicide -- as narrowly defined -- is the only practice at issue in this appeal, and the only practice about which the Coalition takes a position in this brief. Despite the adoption of this terminology for the purpose of this brief, the Coalition agrees with the Ninth Circuit that the phrase "physician-assisted suicide" is neither correct nor proper because the cause of death for the patient who seeks to hasten death is the underlying disease. *Id.* at 802. Indeed, it has been noted that, for the terminally-ill, "the choice is not between life and death, but choosing whether to die now or to die later." Jeremy A. Sitcoff, *Death With Dignity*, 29 J. Marshall L. Rev. 677, 680 (1996).

assistance violated the Equal Protection clause of the Fourteenth Amendment); *Compassion In Dying*, 79 F.3d 790 (holding that a Washington statute criminalizing suicide assistance violated the Due Process clause of the Fourteenth Amendment).

The Coalition defers to the Respondents to suggest a correct standard to be applied on these appeals and will not restate their arguments as to the proper mode of analysis. Rather, the Coalition will marshall and discuss empirical evidence of the circumstances surrounding the end of life that is relevant to the resolution of important issues raised by these appeals irrespective of which Constitutional constraints are applicable.

First, the experience of the Coalition's members makes clear, and the medical evidence confirms, that there are some terminally-ill patients whose suffering simply cannot be relieved, even with the best medical care (including terminal sedation).[3] For such patients, the ability to control the time and manner of death is an extremely important and highly personal matter. Accordingly, in assessing the individual's interests, the Court must recognize the limits of what palliative care can achieve and thus, the strong interests of such patients in relieving unendurable suffering.

Second, the observations of the Coalition's members reinforce their firmly held belief that criminalizing physician-assisted suicide does not serve the State's interests in: promoting life generally; preventing

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[3] Terminal sedation refers to a medically-accepted treatment for terminally-ill patients whose suffering cannot be relieved by other means whereby intravenous drugs (usually barbiturates or benzodiazepines) are administered to induce a pharmacologic coma. Despite some imprecision in the empirical evidence, it has been estimated that between 5% and 52% of dying patients entering home palliative care units have been terminally sedated. Paul Rousseau, *Terminal Sedation In The Care Of Dying Patients*, 156 Archives Internal Med. 1785 (1996).

abuse, mistake and coercion in decisions to hasten death; preserving the integrity of the medical profession; and protecting the dying individual's loved ones. Assisted suicide occurs despite state laws. Were physician-assisted suicide legal, appropriate procedural safeguards could be enacted to ensure that the individual has explored all appropriate palliative care options and is not choosing a hastened death as a result of inadequate efforts to relieve pain and suffering, or any untoward influence. In assessing the legitimacy and/or weight of the States' interests, the Court should consider the experience of palliative care experts and the medical evidence set forth herein which demonstrates that the States' interests are not undermined by permitting physician-assisted suicide.

ARGUMENT

STATUTES THAT PREVENT THE TERMINALLY-ILL FROM OBTAINING MEDICAL ASSISTANCE TO HASTEN DEATH AND END SUFFERING ARE UNCONSTITUTIONAL

As shown below, someone who is suffering grievously on his or her deathbed has a powerful interest in accelerating the time of death. Conversely, the States' proferred interests are furthered by legalizing physician-assisted suicide. Accordingly, the judgments below should be affirmed.

A. Terminally-Ill Patients Have A Powerful Interest In The Legal Ability To Hasten Imminent Death, Relieve Unendurable Suffering And Maintain Their Dignity In The Final Days Of Their Lives.

Hospice professionals are committed to the tenet that patients facing imminent death should be treated compassionately and that they should be able "to make as many choices as possible for themselves -- both in living what is left of life and in dealing with fatal illness."

National Hospice Organization ("NHO") *Amicus* Br. at 3. Accordingly, hospice professionals -- including the NHO -- believe that a terminally-ill patient is entitled to the best palliative care available but is also entitled to the legal option of refusing any medical intervention, including the provision of artificially-supplied hydration and nutrition. *See Id.; Cruzan v. Director*, Missouri Dep't of Health, 497 U.S. 261 (1990). The personal decision of a terminally-ill and suffering individual to hasten death with medical assistance is entirely consistent with hospice philosophy that respects patient autonomy and promotes compassionate treatment. Physician-assisted suicide should be permitted in the rare cases where medical treatments (including terminal sedation and pharmacologically-induced coma) cannot eliminate a dying individual's pain and suffering or are not desired by the patient. Thus, physician-assisted suicide is a compassionate response to an individual's powerful interest in controlling the time and manner of his or her death.

1. All Pain And Suffering Cannot Be Relieved For All Terminally-Ill Patients -- In its medical experience, the Coalition has encountered dying patients whose suffering and misery cannot be relieved with the most aggressive palliative measures. In the face of diseases which destroy the body and rob the spirit, such patients have a powerful interest in obtaining medical assistance to hasten their imminent death.

Hospice professionals know that hospice care can relieve or lessen the physical pain of most terminally-ill patients and that hospices generally provide better palliative care than do non-hospice treatment programs. *See, e.g.*, Jamie H. Von Roenn, *Physician Attitudes and Practice in Cancer Pain Management*, 119 Annals Internal Med. 121 (1993) (reporting that 90% of cancer patients in hospice units report pain relief, whereas 50% to 80% of cancer patients do not have adequate pain control outside

the hospice environment). Nevertheless, all hospice professionals, including the NHO, now acknowledge that irrespective of the efficacy of palliative medicine, there are some patients whose physical pain cannot be relieved adequately. *See NHO Amicus* Br. at 8; Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) ("[I]n a small percentage of cases palliative efforts will fail"); Larry Beresford, *Hospice and the End of Life Debate*, 9 Cal. Hospice Rep. (Summer 1991), at 8 ("Everybody who has worked in hospice for very long knows a handful of cases where the patient's suffering was simply untreatable.").

Hospice professionals also know, and the Second and Ninth Circuits have recognized, that the suffering of the terminally-ill is not merely physical. *See Quill*, 80 F.3d at 729-30; *Compassion In Dying*, 79 F.3d at 812. The mental anguish and personal degradation that precedes death are often more severe than the physical pain. Patients may experience suffering associated with mechanical life-sustaining apparatuses, loss of control over bodily functions, and inability to care for themselves and to participate fully in life activities. In spite of the best palliative care, the prolonged physical deterioration and decay of body, skin, bowels and mind can lead to the reality of existence as a living carcass that can become repugnant to the most caring and stalwart of families, and to the lingering patients themselves. For these patients

> [r]elinquishing control and independence, or compromising personal standards of behavior and "quality of life," may be experienced as worse than death. Ironically, accelerating death becomes a way to preserve the self.

Susan D. Block & J. Andrew Billings, *Patient Requests To Hasten Death*, 154 Archives Internal Med. 2039, 2043 (1994).

Likewise, one nurse practicing home hospice care has described the nature of terminal suffering as follows:

> For many, the pivotal issue is quality of life. Although free of pain, they hate living with the spinal cord compression that left them incontinent of bowel and bladder. Or they hate the inhuman substance that pours from their tumor and onto their clothes, into their hair, onto their furniture. They would rather be dead than live with the brain tumor that has locked them inside a motionless, aphasic body. Like most hospice nurses, my cache of horror stories is endless.

Theresa M. Stephany, *Hospice-Assisted Suicide*, 11 Home Healthcare Nurse 50 (1993). For such patients, accelerating the dying process is the only available relief from suffering that medical professionals can provide.

In addition, terminally-ill patients may have religious or spiritual convictions that render their suffering even more difficult to bear. *See, e.g.*, Timothy E. Quill, *A Midwife Through The Dying Process* (The Johns Hopkins University Press 1996) at 14 ("In Zen Buddhism, how one dies has considerable bearing on how one is reborn in the next life. Being at peace is the best one can hope for and dying in agony puts one at risk.").

As death becomes more imminent, pain and suffering become progressively more difficult to treat. *See* Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms*, 10 J. Palliative Care 31 (1994). For example, terminal agitation (which is also known as terminal restlessness) is a well-documented and heart-wrenching condition that precedes death for many patients, particularly those afflicted with cancer. *See generally* Ian N. Back, *Terminal Restlessness in Patients with Advanced Malignant Disease*, 6 Palliative Med. 293 (1992). Patients suffering from terminal agitation are generally unable to remain still and exhibit motor restlessness such as involuntary muscle twitching or volitional tossing and turning. Terminally agitated patients are also worried, uneasy or anxious. *Id.* This is a particularly distressing

condition for the patient to bear and for his or her loved ones to witness.

In concluding that, in some limited situations, physician-assisted suicide may be the "least terrible of a set of difficult alternatives," hospice professionals have acknowledged the powerful roles that physical distress and the loss of dignity and personal autonomy play in creating an intolerable state of suffering that no medical treatment will alleviate. Block *et ano.*, 154 Archives Internal Med. at 2045. For some patients, such intense suffering is unbearable and leaves them no option but to request medical assistance in hastening their inevitable deaths. *See* Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996) ("Patients who request [physician-assisted suicide] . . . are worried about losing control, being a burden, being dependent, and losing dignity."); Clive Seale & Julia Addington-Hall, *Euthanasia: Why People Want To Die Earlier*, 39 Soc. Sci. & Med. 647 (1994) (reporting that requests for suicide rise as levels of distress and dependency increase); Robert J. Blendon *et al.*, *Should Physicians Aid Their Patients In Dying?* 267 JAMA 2658 (1992) (reporting that not wishing to be dependent upon machines and not wanting to continue living unable to perform most daily activities are reasons frequently cited by terminal patients for hastening death).

Numerous public opinion surveys demonstrate that the majority of Americans favor respecting autonomous decisions by terminally-ill patients to control the manner and circumstances of their death, and support legalization of physician-assisted suicide. *Compassion In Dying*, 79 F.3d at 810 (citing survey data). *See also Knowledge and Attitudes Related to Hospice Care* (Gallup Poll Commissioned by the NHO (1996)). Individuals are particularly likely to favor physician-assisted suicide when they are afflicted with a debilitating and terminal disease. *See* Brett Tindall *et al.*, *Attitudes to Euthanasia and*

Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease, 6 J. Acquired Immune Deficiency Syndromes 1069 (1993) (reporting that "a large proportion of subjects with severe HIV disease in this sample wanted to have the option of euthanasia available should they become severely ill"). Accordingly, the beliefs of the American people are consistent with the experience of the Coalition in dealing with terminal patients on a daily basis, which in turn lead to the inescapable conclusion that dying individuals have a powerful interest in controlling the timing and manner of their death.[4]

2. Terminal Sedation (Pharmacologically-Induced Coma) Does Not Obviate The Choice Of Physician-Assisted Suicide For Those Who Face Imminent Death. -- Opponents of physician-assisted suicide erroneously argue that terminal sedation by use of barbiturates or benzodiazepine to induce unconsciousness obviates the need for assisted suicide. *See, e.g.*, Am. Geriatrics Soc'y *Amicus* Br. at 25. The fact is that terminal sedation has not been proven to eliminate either the pain, suffering or distress of dying patients. Moreover, many patients and the family members who are caring for them at home find the reality of the patient's lingering for days to weeks in a medically-induced comatose state to be antithetical to a good and dignified death. Finally, and ironically, the fact that terminal sedation is practiced by some medical professionals undermines arguments against physician-assisted suicide inasmuch as the practice may also have the "double effect" of hastening death.

Medical professionals have agreed that terminal sedation may be used with the intent to: (1) relieve physical pain; (2) produce an unconscious state before the

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[4] The fact that state legislatures have not repealed ancient statutory prohibitions against physician-assisted suicide is only the weakest kind of contrary evidence of public will, especially where such statutes have gone unenforced for generations.

withdrawal of artificial life support; or (3) relieve non-physical suffering. Robert D. Truog *et al.*, *Barbiturates in the Care of the Terminally-ill*, 327 New Eng. J. Med. 1678 (1992). Terminal restlessness, for example, is commonly treated by putting the patient into a pharmacologic coma. Generally, nutrition and hydration are also discontinued when the patient is under sedation, and the patient then dies of starvation and/or dehydration. Physicians recommend such treatment to dying patients and their families on the grounds that the sedated state will relieve the individual's suffering and enable him or her to die peacefully and "naturally."

Unfortunately, while a terminally-sedated patient exhibits an outwardly peaceful appearance, medical science cannot verify that the individual ceases to experience pain and suffering. To the contrary, studies of individuals who have been anaesthetized (with the same kinds of drugs used in terminal sedation) for surgery (and who are in a deeper comatose state than terminally-sedated patients since their breathing must be sustained by a respirator) have demonstrated that painful stimuli applied to the patient will cause a significant increase in brain activity, even though there is no external physical response. *See, e.g.*, Orlando R. Hung *et al.*, *Thiopental Pharmacodynamics: Quantitation of Clinical and Electroencephalographic Depth of Anesthesia*, 77 Anesthesiology 237 (1992).

Other studies have established that anesthetized patients may continue to perceive and remember events that occur around them despite appearing "unconscious" to others. *See, e.g.*, R.C. Cork *et al.*, *Is There Implicit Memory After Propofol Sedation?* 76 British J. Anesthesiology 492 (1996). Thus, terminally-sedated patients may continue to suffer pain and be aware of their dying condition without being able to communicate their suffering and fears. One can hardly imagine a more distressing and dehumanizing way to die.

Even assuming *arguendo* that terminal sedation could be proven to relieve physical pain and eliminate awareness of death, the treatment is repugnant to many patients who do not wish to prolong the inevitable by lingering in a comatose state. The experience of a terminally-ill cancer patient, Renee Sahm, graphically illustrates the concerns of patients who reject terminal sedation:

> A week later [after Renee's discharge from a hospice unit], Renee's hallucinations and panic set in. Scorpions crawled about her room; over and over, she shouted in fear during an imagined plane crash. Renee tossed violently about in her bed while friends and her attendant provided a twenty-four hour watch -- knowing that the only alternative to the hallucinations would be heavy pharmacologic sedation. But while Renee had still been coherent, she'd spoken adamantly against this very sedation. Her friends agreed: Since she was slipping in and out of periods of coherence, heavy sedation might deprive Renee of important final lucid moments.

Lonny Shavelson, *A Chosen Death*, (Simon & Schuster 1995) at 211.

There are many other valid reasons for rejecting terminal sedation as a sufficient substitute in all cases for physician-assisted suicide. Some patients refuse terminal sedation because of the burden it places on their loved ones, who are often called upon to witness the disintegration of their family member or friend by caring for the comatose body until death. Such care may include frequent turning, care of odorous bed sores, and management of urinary and fecal incontinence. Ironically, a compelling description of the emotional suffering inflicted upon family and friends of terminally-sedated patients comes from a physician who opposes the legalization of physician-assisted suicide:

> Family members caring for a dying loved one who is in the throes of dying, perhaps moaning incomprehensibly or breathing noisily, may find themselves suffering in true compassion. And they may be in doubt, guilt, and confusion: wishing for the death of a loved one whom they will miss -- indeed already miss -- and who they wish was either well and back with them or peacefully gone. This is made all the more poignant and intense by the near-universal sleep deprivation that accompanies this experience.

Ira R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25, 27 (1993). Despite witnessing such suffering, Dr. Byock nonetheless questions whether physician-assisted suicide is preferable. The Coalition submits that each dying patient -- not the State or the patient's physician -- must answer this question for himself or herself. Respecting the dignity of dying patients means respecting that individual's deeply personal choice about how to live in his or her final days. *See Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) ("These matters, involving the most intimate and personal choices a person may make in a lifetime . . . are central to the liberty interest protected by the Fourteenth Amendment.")

It is also significant that terminal sedation is advocated and practiced by the most vehement opponents of physician-assisted suicide even though the patient's death may be hastened. *See, e.g.*, Am. Med. Ass'n *Amici* Br. at 6; Ira R. Byock, *The Euthanasia/Assisted Suicide Debate Matures*, Am. J. Hospice & Palliative Care, Mar./Apr. 1993, at 8, 10. The proffered justification for terminal sedation is based upon the "principle of double effect," whereby medical treatments with the intended effect of relieving pain and suffering are permissible even though a side effect is the hastening of death. Nathan I. Cherny *et ano.*, 10 *J. Palliative Care* at 36.

The Coalition submits that, as a practical matter, the only distinction between terminal sedation and physician-assisted suicide is that the period of time between administration of the lethal agent and death is condensed in physician-assisted suicide. Ascertaining the "intent" of the physician who advocates terminal sedation is a complicated, if not altogether impossible, task. *See* Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993). Indeed, medical professionals know that the practice of terminal sedation is one method of assisting patients in hastening death:

> Justification based on the principle of double effect requires that the clinician intend only to relieve the patient's suffering and not to cause death. When barbiturates or opioids are administered to the terminally-ill, however, both effects are often seen as desirable. The hastening of death in these cases is sometimes referred to as "a blessing in disguise." Justification by double effect may therefore function as a "fig leaf" for euthanasia.

Truog *et al.*, 327 New Eng. J. Med. at 1680. *See also* Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, 25 Hastings Ctr. Rep. 8, 12 (1995) ("[I]t is not clear that relieving terminal suffering by inducing unconsciousness, which may hasten death, is morally superior to voluntary physician assisted death.").

The distinction between terminal sedation and physician-assisted suicide further blurs when one considers that the criteria for terminal sedation are similar to those proposed for physician-assisted suicide. *Compare* Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives Internal Med. 1785 (1996) (Prior to the initiation of sedation, clinicians must ascertain the need for sedating therapy, including the presence of a terminal disease with impending death, exhaustion of all other palliative treatments, agreement by patient and family members of the need for sedation, and a current do-not-

resuscitate order.) *with infra*, pp. 17-18 (Carefully considered guidelines for physician-assisted suicide recommend that the primary care physician document: a terminal diagnosis; a judgment that the patient is mentally competent and not suffering from depression; that high-quality palliative care and hospice care, psychological care and other treatment have been made available to the patient; and that the patient's decision was freely and independently made, without coercion or financial duress.).

B. The States' Interests Are Furthered By Permitting Terminally-Ill Individuals To Exercise This Personal Choice.

The Coalition is convinced that assisted-suicide already exists in fact, far beyond the power of medical professionals, this Court or any legislature to prevent. Many terminally-ill individuals now carry out acts of suicide with the assistance of loved ones. Likewise, there is empirical evidence that medical professionals already assist in acts of suicide cloaked in the sanctity of the physician-patient relationship. Recognizing these unvarnished facts, the question before the Court then, is whether trained medical professionals should be permitted legally to provide a full range of options to terminally-ill patients. For the reasons set forth below, the Coalition submits that medical professionals and terminally-ill patients should be permitted to explore all options for the patient, including the hastening of death, and that this would further the expressed state interests.

1. Physician-Assisted Suicide Now Occurs Secretly Requiring That Appropriate Procedural Safeguards To Protect Terminally-Ill Patients From Coercion And Untoward Influence Be Established. -- Physician-assisted suicide, although presently illegal in most states, is nonetheless a common practice, motivated by the sincere belief of many doctors that it is imperative

for some patients. This practice should be regulated not outlawed.

Surveys demonstrate that there is history of physicians helping their patients to die.[5] In a blind study of primary care physicians in the State of Washington, 26% of doctors surveyed reported that they had received one or more explicit requests for physician-assisted suicide and/or euthanasia, and 12% of doctors surveyed had received such requests within the last year. Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 920 (1996). Physicians provided a lethal prescription to 24% (38 of 156) of the patients who requested physician-assisted suicide. *Id.* at 922. *See also* David J. Doukas *et al.*, *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055 (1995) (reporting that 40% of responding Michigan oncologists reported patient-initiated requests of both assisted suicide and active euthanasia, 18% reported active participation in assisted suicide and 4% reported participation in euthanasia); L. Slome *et al.*, *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. Acquired Immune Deficiency Syndrome 712 (1992) (reporting that 23% of responding physicians who treat AIDS patients would likely grant a patient's request for assistance in hastening death). Thus, medical professionals assist in suicide in spite of statutes criminalizing the practice -- even in states like Michigan where public scrutiny is heightened by media attention to the practice.

The reality of physician-assisted suicide undercuts the States' argument that their statutes effectively control

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[5] Establishing empirical evidence of physician-assisted suicide is impeded by the fact that the practice is illegal in most states. Accordingly, researchers have been forced to conduct blind surveys of physicians, since an open admission could subject the respondent to the risk of criminal prosecution.

the practice. Evidence of substantial defiance of the law, and the obvious conclusion that the States are powerless to prevent it, renders statutes prohibiting assisted suicide merely symbolic, essentially defended as a form of state propaganda of one moralistic view, rather than a realistic regulation of behavior. *See Carey v. Population Services Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring). The challenge then, is to transform those factual observations into a mandate for constructive governance, upholding the individual's liberty interest in the control of his or her own physical being, while at the same time guarding against irresponsible decisions to undertake suicide.

Carefully considered guidelines for assuring just that result have already been promulgated by medical professionals. For example, in the San Francisco metropolitan area a network of ethics committees promulgated the *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill.* Bay Area Network of Ethics Committees, September 1996. Those guidelines provide for safeguards and documenting procedures as part of a high general-care standard for patients with terminal illnesses. The guidelines emphasize that the primary care physician must make an initial referral to a hospice program or to a physician experienced in palliative care. *Id.* at 2. They also recommend that the primary care physician document: (1) a terminal diagnosis; (2) a judgment that the patient is mentally competent and not suffering from depression; (3) that the finest available palliative care and hospice care has been made available to the patient; and (4) that the patient's decision was freely and independently made, without coercion or financial duress. *Id.* at 3. A second, documented opinion from another physician who should have expertise in palliative end-of-life care is also recommended. *Id.* To ensure that the decision was voluntary, the patient must execute a written consent form

twice, with a two-day waiting period between signatures. *Id.* at 3-5. Finally, the guidelines provide for a state registry of all documented cases of assisted suicide. *Id.* Similar careful standards and safeguards have been developed in the States of Michigan and Oregon. Michigan Commission On Death and Dying, *Final Report*, (June 1994) (appending a Michigan Model Statute Supporting Aid-In-Dying); Or. Rev. Stat. § 127.800 (1995) (describing procedural safeguards in Oregon's Death With Dignity Act). *See also* Sitcoff, 29 J. Marshall L. Rev. 677; Charles H. Baron *et al.*, *A Model State Act to Authorize & Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996); Franklin G. Miller *et al.*, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Timothy E. Quill *et al.*, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

Such guidelines, which would properly be enacted by state legislatures, are necessary because, *inter alia*, they minimize the possibility of physician-assisted suicide for those patients who are depressed such that they lack the mental competency to decide whether to accelerate their death. Although depression can be a major factor in an individual's decision to end his or her life and can in some instances impair competency, empirical studies demonstrate that not all patients who express an interest in physician-assisted suicide suffer from depression that impairs competency. William Breitbart *et al.*, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 241 (1996). ("[O]ur data also suggest . . . that not all of patients' interest in physician-assisted suicide is the result of depression."). Palliative care professionals, including psychiatrists, know that it is normal for a terminally-ill and suffering individual to be unhappy, but these professionals have the skill and experience to distinguish between patients who

can make rational and competent decisions and those who cannot.

Moreover, the proposed guidelines would also limit physician-assisted suicide to the terminally-ill. Although some briefs submitted to the Court have raised doubts as to the ability of the medical profession to estimate the life expectancy of their patients, physicians and hospice professionals in fact routinely make just such terminal diagnoses. Indeed, the threshold criterion for enrollment of hospice patients into the federal Medicare and state Medicaid benefit programs is a prognosis of six months or less. 42 U.S.C.A. §§ 1395(d)(d), 1395(f)(i), 1395(x)(dd)(3)(A) (West Supp. 1996); 42 C.F.R. §§ 418.22, 418.200 (1996); *see also NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases*, at 2-3 (1995) (parameters used to determine whether a patient is appropriate for hospice care and eligible for Medicare/Medicaid Hospice Benefit, based on terminal condition).[6] Accordingly, the suggestion that terminal diagnoses are impossible is simply incorrect and flies in the face of routine medical prognostication.

The Coalition submits that the proposed guidelines, which should be enacted by state legislatures, are sufficient to prevent abuse, coercion or improper decision-making. This is due in part to the nature and philosophy of hospice care, and the resulting relationships between hospice professionals and their patients. The parade of horribles envisioned by opponents of physician-assisted suicide is greatly exaggerated. Under a regulated system, a professional would be required to assess whether such patient was experiencing pain, fear or depression which

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[6] The NHO's newly-issued Second Edition Guidelines offers procedural standards to make the same determination, on roughly the same criteria, but now labels it a "life limiting" rather than a "terminal" condition. *See NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases* (2d ed. 1996) at 6-7.

could be alleviated, thereby relegating suicide to an alternative of last resort -- to be used only when all other palliative and psychosocial interventions have been tried and have failed.

2. The Availability Of Physician-Assisted Suicide Promotes The States' Interest In Preserving Life. -- This Court has acknowledged the States' interest in preserving human life. *See, e.g., Cruzan*, 497 U.S. at 282. The Coalition submits that physician-assisted suicide accords with the principle of promoting life because affording a patient the choice to hasten death, should his or her suffering become intolerable, can sustain and preserve that individual's will to live.

Numerous studies have revealed that a significant reason terminally-ill individuals contemplate suicide is the feared loss of control often associated with the progression of many terminal diseases. *See supra* pp. 9-10. Proscribing physician-assisted suicide enhances this sense of impotence by discouraging dying patients from engaging in meaningful discussions with their doctors about the very thoughts that weigh heavily on their minds. Thus, fears about the tolerability of their final days are internalized, rather than shared with experienced professionals. Saddled with such fears, many patients conclude that the only method of preserving self-determination and human dignity is to take their own lives while they are physically and mentally capable of doing so, long before they are disabled by their disease, and often before all possible palliative options have been fully explored. *See* Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 922 (1996); Timothy R. Coté *et al.*, *Risk of Suicide Among Persons With AIDS*, 268 JAMA 2066 (1992); Kay Longcope, *AIDS Related Suicide Up*, Boston Globe, Mar. 17, 1990, at A25.

Allowing doctors to help a mentally competent patient avoid a prolonged and often painful death would

alleviate the some of fear and desperation inherent in a patient's confrontation with his or her imminent mortality. In fact, those doctors who have agreed to assist a patient in ending his or her life have acknowledged that their articulated willingness to provide choice in the face of death gave their patients the security and reassurance to continue to live meaningful lives. For example, Dr. Quill describes his agreement to prescribe barbiturates for a long-time patient and close friend dying of leukemia as follows:

> In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring -- spiritual, legal, professional and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

Timothy E. Quill, *Death & Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). *See also* Betty Rollin, *Last Wish* (Linden Press/Simon & Schuster 1985).

Moreover, many patients who are prescribed lethal medications never actually take them. Back *et al.*, 275 JAMA at 922. And, most of those patients who do use

the drugs to hasten their death do not do so immediately upon receiving them, but rather choose to live longer. *Id.*

The experience of Pierre Nadeau is illustrative on this point. Pierre became deeply depressed when he discovered he was dying of AIDS, and was obsessed with suicide. After his friend Stephen promised that he would help Pierre die if his sickness prevented him from doing it on his own, his depression lifted. When asked whether he would have committed suicide if, at the time he wanted to kill himself, the means had been readily available and legal, Pierre responded, "No . . . . Actually, if it was that easy I would wait, because I'd know that I could do it whenever I wanted to." Shavelson, *A Chosen Death* at 54. *See also* Gina Kolata, *AIDS Patients Seek Solace In Suicide But Many Risk Added Pain In Failure*, N.Y. Times, June 14, 1994, at C1 (reporting that a dying patient who had gathered sufficient lethal drugs but did not use them stated, "Having the means to kill [myself] . . . has diminished my horror, as though I was facing an enemy on a battlefield stark naked and now I have armour.").

In opposing physician-assisted suicide, the States fail to recognize that patients who are denied this personal choice may also be denied the opportunity for positive end-of-life experiences. Such patients may spend their last days worrying about how they are going to hoard enough sleeping pills, or other lethal drugs; hide them from their health care professionals and loved ones until the point when their condition becomes intolerable; and ascertain what method of suicide will end their suffering, rather than intensify it if the attempt fails. A patient may even choose to experience pain in order to create a stash of narcotics to be used later to induce death. The anxiety felt by patients contemplating suicide is enhanced by the knowledge that a botched suicide attempt "may cause [additional] physical suffering, shame, humiliation, and a deepened sense of helplessness." Block *et ano.*, 154

Archives Intern Med. at 2040; Quill, 324 New Eng. J. Med. at 693.

The potential for medical assistance in hastening death can actually provide patients with the sense of control and comfort needed to spend their final days meaningfully examining spiritual issues, and strengthening bonds or resolving conflicts with loved ones -- precisely the type of positive end-of-life experiences that the States incorrectly argue would be diminished by the availability of physician-assisted suicide.

3. The Availability Of Physician-Assisted Suicide Will Support The Integrity Of The Medical Profession. -- The Coalition believes, and the Ninth Circuit has found, that outlawing physician-assisted suicide may diminish the public's trust and respect for the medical profession. *Compassion In Dying*, 79 F.3d at 827. Accordingly, the Coalition submits that each medical professional should be permitted to decide for himself or herself (consistent with appropriate guidelines) whether to assist a terminally-ill patient in accelerating death, and that such assistance is consistent with the proper role of medical professionals in society.

Any evaluation of the integrity of the medical profession must take into account the increasing role that medical technology plays in forcing upon patients what many consider to be unacceptable ways of dying. Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384 (1992). Indeed, medical technology has exacerbated public fear of death. The public knows that doctors tend to overtreat terminally-ill patients. Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994); Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290 (1991). Moreover, when modern medicine fails to provide a cure, some doctors withdraw, forcing a terminally-ill patient to

sustain much of the dying process on his or her own. *Id.*; *see also* Betty Rollin, *Last Wish* (Linden Press/Simon & Shuster 1985). In this context, the number of studies documenting inadequate palliative education and care by doctors and health care professionals is distressing but not surprising. *See, e.g.*, Alfred F. Conners *et al.*, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). Thus, the integrity of the medical profession has been called into question because patients fear that physicians will either overtreat them with life-prolonging technology long after a return of meaningful function is impossible, or abandon them when they need control of symptoms or emotional support.

The public's concern over medical disregard for patient autonomy is also supported by empirical evidence. For example, physicians do not always involve their patients in discussions involving life-sustaining treatment. *See* Terri R. Fried *et al.*, *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 155 Archives Internal Med. 722, 723 (1993). The public's desire for increased self-determination in end-of-life medical decisions has been expressed through the successful ballot initiative for physician-assisted suicide in Oregon and similar referendums in California and Washington. The remarkable popularity of *Final Exit*, a manual for suicide, also testifies to the widespread public desire for certainty about how to end one's life reliably and painlessly. Block *et ano.*, 154 Archives Internal Med. at 2040.[7]

The origins of hospice care are a testament to the medical community's neglect, or inadequate treatment, of

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[7] The availability of information concerning methods of committing suicide does not eliminate the need for legalized assisted-suicide. The hoarded pills and plastic-bag methods advocated in *Final Exit* hardly provide the dignified and certain ending sought by suffering patients. These methods are used in desperation, not dignity.

the terminally-ill. Hospice care developed out of a sense of frustration with the treatment of the dying, and as a reaction against the abuses of an impersonal high-technology approach to patients. Robert J. Miller, 20 *Hospice Care as an Alternative to Euthanasia*, 90 Law Med. & Health Care 127 (1992). Patient autonomy, personal choice and reclaiming control in one's final days of life have always been central to hospice philosophy. *See* Larry Beresford, *Hospice and the End of Life Debate*, Cal. Hospice Rep., Summer 1991, at 6. Thus, hospice professionals believe that a doctor's involvement in the dying process should be sufficiently flexible to account for all personal choices so that the individual need not experience a death characterized by abandonment, pain, impersonality and degradation. Brody, 327 New Eng. J. Med. at 1385.

Prohibiting physician-assisted suicide for suffering patients also undermines doctors' ability to provide the beneficence and comfort historically required of them. Quill *et al.*, 327 New Eng. J. Med. at 1380. The alleviation of suffering is as much a part of traditional medical care as is the prolongation of life. Helping a terminally-ill patient die at his or her request is at one end of the continuum of lifelong medical care when healing becomes impossible -- as it does in every life. Faye J. Girsh, *Physicians Aid in Dying: What Physicians Say, What Patients Say*, 157 W. J. Med. 188, 189 (1992); Block *et ano.*, 154 Archives Internal Med. at 2040.

Increasing the role of physicians, hospice and other medical professionals in the process of dying will enhance the public's respect for the medical profession on both an individual and institutional level. Brody, 327 New Eng. J. Med. at 1385 (1992); Franklin G. Miller *et al.*, 331 New Eng. J. Med. at 119 (1994). On an individual level, it will enable doctors and patients to talk about what the end will be like, thereby reinforcing the doctor-patient relationship. Because doctors often have intense

relationships with dying patients, a doctor's refusal to help a patient hasten death "may be experienced by the patient as an abandonment, a rejection or an expression of inappropriate paternalistic authority." Block *et ano.*, 154 Archives Internal Med. at 2045. In addition, open communication about what is causing the patient to make such a request will be fostered, and may ultimately lead to improved management of the distressing symptoms. Brody, 327 New Eng. J. Med. 1394. The doctor's role in enabling a patient to choose a good death is vital because patients lack the technical knowledge and skill, acting independently, to end their lives in a certain and humane manner. Those inclined to end their lives will not be prevented from doing so if physician-assisted suicide is illegal; they will instead opt for more grisly and less effective means.

On an institutional level, legalized assisted-suicide will enable physicians to consult with one another about a patient's request to hasten death, which also increases the likelihood that the patient's condition will be fully examined. Back, 275 JAMA at 925; Miller *et al.*, 331 New Eng. J. Med. at 121; Quill *et al.*, 327 New Eng. J. Med. at 1383. Moreover, legalization and regulation will put a clear responsibility on doctors to assess and treat depression and pain, commonly present and insufficiently treated in patients with terminal illnesses. Howard Brody, *Physician-Assisted Suicide Should Be Legalized*, 53 Archives Neurology 1182 (1996). Thus, the need for physician-assisted suicide would be reduced.

The States' argument that physician-assisted suicide undermines the public's respect for the medical profession lacks merit since physicians now engage in many legal practices to accelerate death for their patients. All hospice professionals, including the NHO, agree that physicians may terminate life-support systems, withhold all other forms of medical treatment, and may even administer drugs to sedate with full knowledge of their

"double effect." NHO *Amicus* Br. at 3; Miller *et al.*, 331 New Eng. J. Med. 119. Physicians who prescribe drugs to hasten death will not be looked upon as "killers" any more than physicians who now take actions, such as disconnecting respirators, that result in the deaths of their patients. *See Quill*, 80 F.3d at 730; *Cruzan*, 497 U.S. at 296-98 (Scalia, J., concurring) (no distinction between action and inaction when both result in death). To deny dying patients the right to choose self-administered prescription drugs as an alternative to assured anguish and degradation, and then to hide this prohibition under the veil of protectionism, is offensive not only to individual autonomy, but also to the will of the American populace, who, as surveys indicate (*see supra*, p. 9) want this choice to be legal.

4. The Availability of Physician-Assisted Suicide Protects The Interests Of Family Members And Loved Ones. -- The states also assert an interest in protecting the family and friends of terminally-ill individuals. The Coalition submits that affirming the lower courts' decisions furthers that interest by ensuring that family members and friends will not be forced to choose between witnessing a loved one suffer a slow and agonizing death, or acting to assist him or her to end the suffering.

The Coalition knows that the family and friends of terminally-ill individuals experience painful feelings of helplessness and guilt at impotently watching a loved one's prolonged suffering. See, e.g., Betty Rollin, *Last Wish*. Thus, these people often empathize with their loved one's desire to hasten death.

While it is impossible to account for the number of suicides by the terminally-ill that have involved the assistance of family members or friends, there is evidence that the practice exists:

> Family members, family physicians, friends, and even freelance euthanasists . . . are now assisting in

> suicides with no more guidance than their own limited personal experiences and rules. No survey, no poll, no investigation, no educated guesses will ever yield knowledge of the number of people who have died by overdoses, plastic bags, self-inflicted gunshot wounds, or physician-administered lethal drugs -- when they should instead simply have had good counseling and better medical treatment of their pain, shortness of breath, or depression.

Shavelson, *A Chosen Death* at 103. *See also* Miller *et al.*, 331 New Eng. J. Med. 119. Moreover, such attempts frequently fail -- with tragic consequences for the terminally-ill individual. *See, e.g.*, Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12 (describing academic study which "shows that in the absence of regulation and medical supervision, [assisted-suicide] is occurring in horrific circumstances, like back-street abortions."); Kolata, N.Y. Times, June 14, 1994 C1 (reporting instances of unsuccessful assisted suicides including story of Illinois man who tried to smother terminally-ill friend with a pillow but instead asphyxiated him just enough to destroy most of his brain's functions).

In addition, prohibiting physician-assisted suicide adversely affects the bereavement process of family members and friends of a terminally-ill patient who chooses to hasten death. Patients seeking to protect their loved ones from potential criminal prosecution are likely to plan and commit suicide without informing them. The secrecy surrounding such a death instills confusion, guilt and uncertainty in the survivors which hampers their grieving process. In addition, where the loved one provides assistance in hastening death, the secrecy is compounded since he or she is unable to talk about the death for fear of adverse legal consequences.

One of the most consistent findings in the clinical bereavement literature is the importance of social support for the survivors. When the mourner perceives that

support is not available or that the loss is not socially acceptable or acknowledged, there is an increased risk for complicated mourning. Therese A. Rando, *Treatment of Complicated Mourning*, 495 (Research Press, Champaign, IL 1993). Confiding in others plays a central role in the coping process; behavioral inhibition places cumulative stress on the body and increases the long-term possibility of stress-related disease and psychological damage. J.W. Pennebaker, R.C. O'Herron, *Confiding in Others and Illness Rates Among Spouses of Suicide and Accidental-death Victims*, 93 J. of Abnormal Psych., 473-476 (1984).

Legalization of physician-assisted suicide would provide an environment in which the dying person is not forced to act in secret and one in which family members could be present at the assisted death and discuss it in an open and healthy fashion. Additionally, legalization would enable family members and friends, who wish to honor their loved one's request for help to end his or her intractable suffering to obtain the assistance of experienced physicians. This is clearly preferable to exposing family members and friends to the legal, medical and psychological risks presently associated with assisting a loved one to die.

CONCLUSION

For the foregoing reasons, and for those set forth in the Respondents' briefs, the judgments below should be affirmed.

Respectfully submitted,

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APPENDIX

The Coalition's members are representative of every facet of the hospice caregiving team. These palliative care specialists practice in hospices and hospitals throughout the country; serve on ethics committees and policymaking boards; instruct medical students; and are responsible for the operation of individual hospices, hospice systems, specialized clinics, and family medical practices.

The Coalition's members are: Rev. Diane Bagues, hospice chaplain; Robert Bendiksen, Ph. D., professor, University of Wisconsin-LaCrosse, member of Gunderron Lutheran IRB/Human Subjects Subcommittee; Zail Berry, M.D., former medical director of Washington, D.C. Home and Hospice; Robert Brody, M.D., chief, Pain Consultation Clinic and chair, Ethics Committee, San Francisco General Hospital and clinical professor of Medicine, University of California, San Francisco; Michael J. Cassidy, M.D., medical director Hospice Visiting Nurse Association and Hospice of Northern California; Joanna Cooper, M.D., clinician, East Bay Neurology, Berkeley, California; William Curtis, M.D., radiologist, member of Hospice Ethics Committee, member of Boulder County and Colorado Medical Society, emeritus member of American Medical Association; Susan Edenborough, director, Crossroads Home and Hospice, San Francisco; Jonathan Gavrin, M.D., anesthesiologist, internist and palliative care specialist, and a member of the faculty at University of Washington and Fred Hutchinson Cancer Research Center; David Hibbard, M.D., family practitioner, Hospice Ethics Committee member; Sarah Hogenauer, R.N., M.S., coordinator, Hospice Care Network, Westbury, New York; Constance Holden, R.N., M.S.N., clinical nurse specialist, executive director of

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Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,
Petitioners,

—v.—

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

STATE OF WASHINGTON, *et al.*,
Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURTS
OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL STUDENT ASSOCIATION AND A COALITION OF DISTINGUISHED MEDICAL PROFESSIONALS IN SUPPORT OF RESPONDENTS

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P.J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699 (1996) 18

Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844 (1989) 13

INTEREST OF *AMICI CURIAE*

The American Medical Student Association ("AMSA") and an ad hoc coalition of distinguished medical professionals respectfully submit this brief as *amici curiae* in support of Respondents. We file this brief with the consent of all parties.[1]

Founded in 1950, AMSA is an independent, non-profit organization representing nearly 30,000 physicians-in-training from medical schools across the country. AMSA, thus, represents the future of medicine in the United States.

The individual *amici*[2] are licensed medical professionals and educators with both clinical and academic expertise in the end-of-life issues confronting terminally ill patients. Some of us have written papers and articles on the clinical and bioethical aspects of end-of-life medical decisions; others have participated in the writing of guidelines and model statutes for the regulation of physician-assisted suicide. As a result of our experience, we are among the growing number of medical professionals who believe that, in certain limited and carefully-regulated circumstances, physician-assisted suicide should be a lawful option available to competent, terminally ill patients.[3]

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1. Copies of letters of consent are being filed with the Court at the same time as the filing of this brief.

2. See Appendix A for a fuller description of each of the individual medical professional *amici*.

3. *See, e.g.*, David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 New Eng. J. Med. 663, 666 (1996) ("Surveys of physicians demonstrate . . . majority support" for physician-assisted suicide.) ("Orentlicher, *Legalization*") (citations omitted); Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 New Eng. J. Med. 303, 306-07 (1996) (56% of Michigan physicians support legalization of physician-assisted suicide); Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1807 (1996) ("Emanuel, *Oncology Patients*") (45.5% of oncologists agree with physician-assisted suicide for patients in unremitting pain); Jonathan S. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians In Washington State*, 331 New Eng. J. Med. 89, 89 (1994)

We recognize that, for most patients, palliative care options exist and a physician can adequately ease a patient's suffering even when there is no cure for the patient's underlying condition. For this reason, we strongly support hospice and other comprehensive palliative care initiatives as the standard of care for the dying. When appropriate palliative care is adequate to relieve the patient's pain and suffering, we do not believe that physician-assisted suicide is an advisable option.

However, we also recognize that even the highest quality palliative care will not always adequately ease a patient's suffering. In such exceptional circumstances, mentally competent terminally ill patients should have the option of a safe, legal and state-regulated means of hastening death with the assistance of a physician.

SUMMARY OF ARGUMENT

Terminally ill patients who are competent and make a voluntary choice to hasten their death with the assistance of their physician should have the same right to control the time and manner of death as patients who refuse life-sustaining treatment. There is no clinical basis for distinguishing these two classes of patients based on purported categorical differences in either (*i*) the intent of the patient or the physician or (*ii*) the extent to which the active intervention of the physician affects the time and manner of the patient's death. Furthermore, criminal prohibition of assisted suicide compels many terminally ill patients to surrender their right to refuse unwanted and degrading medical treatment in order to relieve otherwise untreatable pain.

Petitioners' interests in protecting the ethical integrity of the medical profession and in limiting physician-assisted suicide to

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(54% of Washington doctors believe physician-assisted suicide should be legal in some situations).

competent, terminally ill patients who voluntarily choose to hasten their deaths also fail to support their general prohibition of the practice. Preventing physicians from assisting such patients is inconsistent with important principles of medical ethics because it may force doctors to abandon their patients, and to ignore their requests for information, assistance, and comfort, at a time when the patient is most in need because he or she is confronting both severe suffering and imminent death. Nor is it necessary to force competent patients to endure a prolonged, painful, and pointless process of dying in order to ensure that the practice of physician-assisted suicide is appropriately regulated. Detailed regulatory schemes have already been promulgated which involve the same types of medical judgments and legal protections that have been successfully used in other, long-established end-of-life decisions.

ARGUMENT

I. THE CLINICAL REALITIES OF TERMINALLY ILL PATIENTS DO NOT JUSTIFY THE LEGAL DISTINCTIONS URGED BY PETITIONERS.

Petitioners contend that it is constitutionally permissible for them to distinguish between the withdrawal or refusal of life support and physician-assisted suicide. Their justifications for such a distinction, however, simply ignore the clinical realities of terminally ill patients. Furthermore, in many instances, the artificial distinctions Petitioners seek to draw merely compel patients who are not on life support to surrender their right to refuse dehumanizing medical treatment in order to escape prolonged and intolerable suffering.

A. Medical Realities Do Not Support A Bright-Line Legal Distinction Between Refusal Of Life Support And Assisted Suicide.

The patients who brought these cases sought the same general right that this Court recognized in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990): to exercise the deeply personal choice to hasten the end of their lives as the only alternative to a painful and degrading process of dying. In denying this right to patients who seek the aid of their doctors in hastening their death, Petitioners rely on three purported categorical distinctions between such patients and those who refuse life-sustaining measures:

- whether the physician or the patient intend the patient's death or merely know that it is a foreseeable consequence of the physician's efforts to relieve suffering;
- whether the physician acts to hasten death or merely fails to take actions to prevent or delay death; and
- whether the time and manner of the patient's death is caused by medical intervention or is the "natural" result of an underlying illness.

These purportedly dispositive differences in intent, action, and causation, however, simply do not withstand scrutiny in light of the medical and clinical realities of terminally ill patients and their treatment. *See generally* Orentlicher, *Legalization* at 663 (explaining why categorical distinction between refusal of treatment and assisted suicide is no longer appropriate in light of changes in medical treatment of terminally ill patients).

1. Terminally Ill Patients And The Physicians Who Aid Them In Dying Intend To Give The Patient Control Of The Process Of Dying.

Petitioners contend that the intent of patients and physicians who participate in physician-assisted suicide is necessarily different from that of the patient and physician who refuse, withhold, or withdraw life-sustaining measures. In the case of physician-assisted suicide, the specific intent purportedly must be the death of the patient, *see Vacco* Pet'r Br. at 15-16; *Glucksberg* Pet'r Br. at 44, while where life-sustaining treatment is being refused, death is merely an unintended, albeit often inevitable, consequence of a desire to relieve the patient's suffering and indignity, *see Vacco* at 13-14. There is simply no basis, however, for presumptively ascribing such different intentions and purposes to patients and physicians in these two circumstances.

Such a simplistic and arbitrary account of the intentions of those who participate in physician-assisted suicide trivializes the inherently complex and multiple motivations involved in any end-of-life decision. *See* Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993) ("Quill, *Ambiguity*"). Thus, in requesting and prescribing a potentially lethal dosage of medication, the immediate goal of both patient and physician may be nothing more than to give the patient "a greater sense of control" over the process of dying and both may hope that the patient is never forced to take this final step in order to relieve their suffering. N.Y. Task Force On Life and Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 83 (1994) ("N.Y. Task Force Report"); *see also* Quill, *Ambiguity*; Timothy E. Quill, *Doctor, I Want to Die*, 7 JAMA 870, 872 (1993).

Indeed, in many cases, patients who have been prescribed

a lethal dosage never take the medication.[4] Rather, the medication serves its intended purpose by reassuring the patient that their terminal condition need not lead to dependency or indignity. *See, e.g.*, Susan D. Block, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2045 (1994) ("Block, *Patient Requests*") ("[A]cceptance of the patient's wish for hastened death . . . may paradoxically allow the patient enough control and confidence in his or her ability to manage the future so that the option of suicide does not have to be exercised."). For some patients, this sense that they retain control of their lives provides sufficient comfort to make their final days bearable. *E.g.*, Kingsley Decl. ¶¶ 11-12 (*Vacco* J.A. 99, 101-02); Grossman Decl. ¶¶ 15 (*Vacco* J.A. 84, 87); *see also* N.Y. Task Force Report at 92 ("The most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, un[a]esthetic, absurd, and existentially unacceptable condition.").

Even where the patient chooses to hasten her death, her ultimate goal is no different from that Petitioners ascribe to those who reject life sustaining treatment: to avoid a prolonged and dehumanizing process of dying. No less than those on life support, such patients seek to hasten death "because the quality of life during the time remaining . . . ha[s] been terribly diminished" and their life "has been physically destroyed and its quality, dignity and purpose gone." *See Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986) (describing patient's reasons for withdrawal of life support). Regardless of the means by which death is hastened, the intent and purpose of both categories of terminally ill patients are essentially the same.

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4. *See, e.g.*, Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) ("Back, *Physician-Assisted Suicide in Washington*"); Andrew Solomon, *A Death of One's Own*, New Yorker, 54, 58 (May 22, 1995) ("Solomon, *Death of One's Own*").

2. A Physician Who Withdraws Life Support Actively Causes The Patient's Death.

Equally meritless is Petitioners' attempt to distinguish assisted suicide from withdrawal of life support by arguing that, in the latter case, the physician takes no affirmative action that causes the patient's death. *See Vacco* Pet'r Br. at 17; *Glucksberg* Pet'r Br. at 30. This contention simply ignores the clinical reality of life-sustaining technology. For example, to disconnect a respirator, a physician or nurse must take each of the following steps:

1. turn off the respirator;
2. disconnect the machine from the tube that goes to the patient's lungs;
3. remove the tube from the patient's lungs;
4. administer morphine or barbiturates to ease the patient's sense of suffocation; and
5. monitor medication levels to ensure that symptoms of severe air hunger do not arise.

See Quill Supplemental Decl. ¶ 5 (*Vacco* J.A. 116-117) ("Quill Supp. Dec.").[5]

Furthermore, it is clear that when a patient is subject to on-going life-sustaining treatment, the withdrawal of that treatment will be a cause of the patient's death. For example, when a physician stops a respirator, death results because breathing stopped, but the cause of death is also the physician's act in halting the respirator. *See McKay v. Bergstedt*, 801 P.2d 617, 634 (Nev.

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5. Furthermore, when a patient refuses or requests withdrawal of life support, the physician may dispense drugs that ease the patient's suffering, but also hasten death. For example, when a doctor stops a patient's food and hydration, the ensuing bodily reaction requires the physician to treat these symptoms with sedatives that may hasten the patient's death. Quill Supp. Dec. ¶ 6 (*Vacco* J.A. 117-18).

1990) (Springer, J., dissenting). Similarly, when a physician halts food and hydration, death occurs because the patient is unable to eat or drink, but the physician is causally responsible for the death as a result of issuing the order to stop providing food and hydration. *See Brophy v. New Eng. Sinai Hosp. Inc.*, 497 N.E.2d 626, 631 (Mass. 1986) (Nolan, J. dissenting) (explaining that removal of feeding tube leads to death by dehydration and starvation). There can be no question that if a physician performed either of these actions without the patient's consent, she would be legally responsible for causing the patient's death just as surely as if she had shot her patient. *See* Orentlicher, *Legalization* at 663.

3. The Medical Environment In Which Terminally Ill Patients Typically Spend Their Final Days Necessarily Affects The Time And Manner Of Their Death.

Petitioners finally argue that refusal or withdrawal of life-sustaining measures and physician-assisted suicide are materially different because, in one case, the time and manner of death are the result of "natural" processes, while, in the other, they are affected by the action of physicians and other medical professionals. *See Vacco* Pet'r Br. at 17-18; *Glucksberg* Pet'r Br. at 12, 30, 38. This distinction also ignores the clinical reality of terminally ill patients.

It is a fundamental fact of contemporary medicine that death rarely occurs "naturally" and apart from significant medical intervention. Indeed, in 1992 nearly 80% of all deaths in this country occurred in hospitals. *See* Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Cal. L. Rev. 857, 858 (1992). In such a setting, both the time and manner of a patient's death are necessarily often the result of a series of conscious decisions and affirmative actions by the patient and her physicians.

In particular, the extensive medical treatment received by

most terminally ill patients will often have collateral consequences that affect both the timing and the manner of the patient's ultimate death in a way that makes it meaningless to describe death as occurring "naturally." *See, e.g.*, Froom Decl. ¶ 11 (*Vacco* J.A. 125, 126) ("With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt.").[6] For example, a cancer patient's chemotherapy may temporarily treat the illness, but it also may damage vital organs in the process and thereby affect when and how the patient may die. *See Clinical Oncology*, 789-813 (Martin D. Abeloff et al. eds 1995) (describing pulmonary and cardiac complications resulting from cancer therapy). Because the precise circumstances of death for most terminally ill patients will be determined in part by the effect of such medical interventions, the death of such patients cannot fairly be described as "natural."

B. Terminally Ill Patients Should Not Be Forced To Choose Between Enduring Severe Pain And Surrendering Their Constitutional Right To Avoid Unwanted And Dehumanizing Medical Treatment.

Although Petitioners and their *amici* suggest that adequate palliative care options are virtually always available for terminally

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6. The affidavits of the patients who brought the *Vacco* action graphically illustrate some of the effects of such treatments on terminally ill patients. *See, e.g.*, Barth Decl. ¶¶ 3-4, 9-10 (*Vacco* J.A. 96, 97-98) (describing adverse side effects of treatments for disease); Doe Decl. ¶ 10 (*Vacco* J.A. 106, 107) (describing scarring inside throat and neck from surgery and radioactive iodine treatment; burning and swelling in neck and nausea from radiation therapy; pain, nausea, and vomiting from tube feeding); Kingsley Decl. ¶ 8 (*Vacco* J.A. 101) (describing "cramping," "gas with bloating" and "total loss of appetite" from medication to prevent infection; administration of medication through Hickman tube connected to chest artery prohibited showering and made simple routine functions burdensome).

ill patients, *see, e.g., Glucksberg* Pet'r Br. at 18; American Medical Association ("AMA") *Vacco* Br. at 6-7, they ignore the cruel and dehumanizing nature of the "care" that may be required and the extent to which it may compel the patient to surrender his or her right to refuse unwanted and degrading medical treatment. In some instances, palliative care for terminally ill patients also impairs those patients' most basic bodily functions.[7] "Adequate" palliative care may also require extended periods of sedation to the point of permanent or temporary unconsciousness. *See* AMA *Vacco* Br. at 6 ("For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or *weeks of life* to prevent the patient from experiencing severe pain.") (emphasis added).[8] Indeed in some cases, patients may be sedated to the point where they require life support and then are "allowed to die" by withholding the necessary life-sustaining treatment.[9] This last practice

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7. *See, e.g.* Kingsley Decl., ¶ 8 (*Vacco* J.A. 101); Grossman Decl. ¶¶ 13-14 (*Vacco* J.A. 86-87).

8. *See also* Robert E. Enck, *The Medical Care of Terminally Ill Patients* 166-172 (1994) (summarizing recent studies on degree and frequency of sedation of terminally ill patients); Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Med. 1785, 1786 (1996) ("some [terminally ill] patients may require profound sedation"); Nathan I. Cherny et al., *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. of Palliative Care 31, 36 (1994) (adequate palliative care for the terminally ill may require sedation involving permanent or temporary "total loss of interactional function"; attempts to adjust dosages of sedatives "to reestablish lucidity after an agreed interval or for pre-planned family interactions" risk "possibility that lucidity may not be promptly restored or that death may ensue as doses are again escalated"). In addition, there can be no certainty that a patient who has been sedated to unconsciousness will, in fact, cease to experience pain. *See* Michael P. McQuillen, *Can People who are Unconscious or in the "Vegetative State" Perceive Pain?*, 6 Issues in L. & Med. 373 (1991).

9. *See* Robert J. Hall, *Final Act: Sorting Out the Ethics of Physician-Assisted Suicide*, 54 Humanist 10 (Nov./Dec. 1994) ("Hall, *Final Act*") ("The most recent answer to such problems, which may well become standard practice, is to sedate these patients into complete unconsciousness and to withhold nutrition and hydration until they die."); Timothy E. Quill et al.,

illustrates the utter artificiality of the line Petitioners seek to draw.

Terminally ill patients may refuse such palliative care based on their right to refuse unwanted medical treatment. *E.g., Cruzan*, 497 U.S. at 279; *Vacco* Pet'r Br. at 10. But the price of exercising this right is to remain conscious and to suffer both intolerable pain and an awareness of all of the indignities resulting from the ravages of the illness and its treatment. Doe Decl. ¶ 9 (*Vacco* J.A. 107) ("[I]t is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state."); Klagsbrun Decl. ¶ 16 (*Vacco* J.A. 71) ("Pain management at the end stage of cancer often requires the patient to choose between enduring unrelenting pain or sacrificing an alert mental state to the high dose of drugs adequate to alleviate pain."). In short, for some terminally ill patients, the choice Petitioners offer between palliative care or extreme pain and suffering is both cruel and meaningless.

II. PHYSICIAN-ASSISTED SUICIDE IS FULLY CONSISTENT WITH PETITIONERS' INTEREST IN PROTECTING THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION.

Petitioners' contention that they can require terminally ill patients to endure unnecessary and intolerable suffering in order to vindicate their interest in maintaining the integrity and ethical standards of the medical profession, *see Vacco* Pet'r Br. at 14-15, 31-32, is equally misplaced. As even those who support Petitioners' position, such as the AMA, acknowledge, established principles of medical ethics fully support a physician providing

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Physician-Assisted Death: A Comparison of Terminal Sedation, Assisted Suicide, and Voluntary Active Euthanasia, (manuscript at 8, on file with author) ("the suffering patient is put into an iatrogenic coma, usually using barbiturates or benzodiazepines, and then dies of dehydration, starvation, or some other intervening complication, as all life-sustaining interventions are withheld").

medication that will hasten a patient's death where the patient has voluntarily chosen this outcome as the only means of relieving severe suffering. Petitioners and the AMA argue, however, that the same conduct becomes unethical where a physician frankly acknowledges, or otherwise reveals, that her aim is to assist the patient in controlling the time and manner of their death. This distinction, however, makes no sense as a matter of professional ethics or public policy. Indeed, the criminal prohibition of physician-assisted suicide prevents doctors from fulfilling important ethical obligations to dying patients and encourages furtive practices that are akin to voluntary euthanasia and have a greater potential for abuse.

A. The Prohibition Of Physician-Assisted Suicide Is Inconsistent With The Medical Profession's Obligation To Respect Patient Autonomy And To Comfort Rather Than Abandon The Dying.

Petitioners' criminal prohibition of physician-assisted suicide conflicts with the medical profession's well-established ethical obligations to respect patient autonomy and to continue to attend to and comfort their patients, even when they may have an incurable illness. Indeed, it forces doctors to choose between violating the law and abandoning patients at a time when they are most in need and have expressed a desire to hasten their death as the only way of avoiding intolerable and untreatable suffering.

A traditional role of the physician, and a central goal of medicine, is to help people die with meaning, comfort and dignity. *See* AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, Opinion 2.20, at 40 (1996) ("*AMA Code*") ("Physicians have an obligation to relieve pain and suffering and to promote the

dignity and autonomy of dying patients in their care.").[10] In addition, as the AMA Council on Ethical and Judicial Affairs acknowledges in its opinion on physician-assisted suicide, medical ethics mandate that "[p]atients should not be abandoned once it is determined that cure is impossible." *AMA Code*, Opinion 2.211, at 56.[11] Indeed, "[t]o allow a [terminally ill] patient to experience unbearable pain or suffering is unethical medical practice." Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 847 (1989).

The principle of patient autonomy is equally central to medical ethics and to defining the physician's role in end-of-life decisions. As the AMA Council on Ethical and Judicial Affairs stated in its opinion on withholding or withdrawing life-sustaining medical treatment, "[t]he social commitment of the physician is to sustain life *and* relieve suffering. *Where the performance of one duty conflicts with the other, the preferences of the patient should prevail.*" *AMA Code*, Opinion 2.20, at 39 (emphasis added); *see also id.* at 40 ("Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying

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10. *See also* Medical Society of the State of New York, *Principles of Professional Conduct*, ch. 1, § 1 (1995-96) ("The prime object of the medical profession is to render competent medical service with compassion and respect for human dignity."); Eric J. Cassel, *The Nature of Suffering and the Goals of Medicine*, 306 New Eng. J. Med. 639, 639 (1982) ("The obligation of physicians to relieve human suffering stretches back into antiquity."); Hall, *Final Act*; John R. Peteet, *Treating Patients Who Request Assisted Suicide -- A Closer Look at the Physician's Role*, 3 Archives Fam. Med. 723, 726 (1994).

11. *See also AMA Code*, Opinion 8.11, at 123 ("Once having undertaken a case, the physician should not neglect the patient."); Howard Brody, *Assisted Death -- A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) ("[W]alking away, denying that medicine can do anything to help in the patients's plight, is an immoral abrogation of medical power, especially in cases in which the prior exercise of the medical craft has extended the patient's life and resulted in the complications that have brought the patient to the present state of suffering."); Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 Annals Internal Med. 368, 368 (1995).

patients in their care.").[12] Each patient must be allowed to make life-and-death decisions within the broader context of her own beliefs concerning the purpose and value of her existence. After all, "health and life extension are ultimately of value in the service of the broader overall well-being of the patient. They are of value in so far as they facilitate the patient's pursuit of his or her overall plan of life; the aims, goals and values important to the particular patient." Dan W. Brock, *Death and Dying*, in *Medical Ethics* 329, 334 (Robert M. Veatch ed. 1989). Thus, medical professionals should respect a patient's decision to hasten her death when the patient's remaining life offers nothing more than an intolerable and undignified process of dying. *See AMA Code*, Opinion 2.211, at 56 ("It is understandable, though tragic, that some patients in extreme duress -- such as those suffering from a terminal, painful, debilitating illness -- may come to decide that death is preferable to life.").

B. A State's Interest In Preventing Doctors From Intentionally Harming Patients Does Not Justify A General Prohibition Of Physician-Assisted Suicide.

Petitioners and their supporting *amici* contend that their interest in maintaining the integrity of the medical profession justifies a general prohibition against intentionally hastening the death of a patient even where precisely the same conduct would be lawful if done solely to relieve the patient's suffering. This distinction between instances where a doctor intentionally assists a patient in ending her life and so-called "double effect" cases in

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12. AMA Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992) ("[The AMA recognizes that] a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.").

which death is foreseeable, or even certain, but purportedly not intended is not supported by either medical ethics, legitimate policy considerations, or common sense.[13]

Petitioners argue that the principle that doctors should not intentionally harm their patients trumps all the other ethical considerations that support physician-assisted suicide.[14] This takes an unreasonably narrow view of what may constitute harm for a patient suffering irremediable and severe pain and confronting an imminent and unavoidable death. For such a patient, death may constitute not harm but the only available relief; the true harm may lie in being compelled either to continue unnecessary suffering or

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13. The AMA formally explained its position on the "double effect" doctrine in an opinion by its Council on Ethical and Judicial Affair which stated that "pain medications may be [ethically and legally] administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of . . . causing death through respiratory depression." AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 95 (1994); *see also AMA Code*, Opinion 2.20, at 40.

14. Although the AMA relies on the Hippocratic Oath for this proposition, *see* AMA *Vacco* Br. at 5, it is clear that the Oath does not represent the best or final word on modern medical ethics and controversies. Even at its inception, the Oath was not accepted by all ancient physicians. *See Roe v. Wade*, 410 U.S. 113, 131-32 (1973); *Encyclopedia of Bioethics*, Appendix at 2632 (Warren T. Reich ed., rev. ed. 1995). In fact, the strict provisions of the Oath forbid many medical procedures which are widely accepted today as ethical or legal, including abortion, "double effect" pain medication, and even surgery in any form. *See Encyclopedia of Bioethics*, Appendix at 2632 ("I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. . . . I will not use the knife, . . . but will withdraw in favor of such men as are engaged in this work.") (quoting Hippocratic Oath). For this reason, it has often been "retranslated" or modified. *See, e.g.*, Noah Adams, *Doctor Examines Evolution of Hippocratic Oath*, National Public Radio transcript #2199-4, April 30, 1996 (noting that at Johns Hopkins Medical School, the oath used at graduation ceremonies has been altered to "I will give no drug or perform no operation without a justifiable purpose."). Thus, the Hippocratic Oath should have no greater weight here than it did in determining whether women have a constitutional right to an abortion. *See Roe*, 410 U.S. at 131-32.

to end one's life in a lonely and violent manner.[15]

Furthermore, by sanctioning the practice of directly administering medications that will foreseeably cause a patient's death, the "double effect" doctrine allows physicians to engage in practices that are far closer to voluntary, or even involuntary, active euthanasia than physician-assisted suicide. *See* Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 N. Eng. J. of Med. 1678 (1992) (describing practice of administering barbiturates to relieve pain of terminally ill patients with unavoidable side effect of hastening death).

Nor is there any basis for believing that an open and legal practice of physician-assisted suicide would undermine patients' trust in their doctors because patients will come to view their doctors as killers. *See* AMA *Vacco* Br. at 21. First, it is difficult to see how more openness in the doctor-patient relationship will lead to less trust. To the contrary, imposing criminal liability only where there is evidence of the physician's intent to hasten death has

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15. Examples of such suicides are numerous: patients have jumped from bridges, withheld their own insulin to die of insulin shock, shot themselves in the head, suffocated themselves with plastic bags, and taken overdoses of prescription or over-the-counter drugs. *See, e.g., Compassion in Dying v. Washington*, 79 F.3d 790, 834-35 & n. 135 (9th Cir.), *cert. granted*, 117 S. Ct. 39 (1996); *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996); Solomon, *Death of One's Own*, at 57. Moreover, a patient who seeks to commit unassisted suicide (or suicide assisted by a layperson) is most likely unaware of what drugs or dosage they must use. Physical inability or miscalculation can lead to an even more drawn-out, painful and undignified death. *See, e.g.*, Russel D. Ogden, *Euthanasia: Assisted Suicide & AIDS* (1994) (approximately half of the layperson-assisted suicides were unsuccessful and increased the patient's suffering, rather than mitigating it); *Compassion in Dying*, 79 F.3d at 836 n.135; *Quill*, 80 F.3d at 721 ("Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts."). In addition, the negative effects of a violent unassisted suicide on the patient's family members extends the tragedy far beyond the individual patient. *See, e.g., Compassion in Dying*, 79 F.3d at 835 ("My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.") (quoting Brief of Amicus Curiae of Ten Surviving Family Members). When a family member assists the suicide, the negative effects can be irremediable. *See id.* at 835-36 & n. 135-36.

a chilling effect on the patient's ability to communicate freely with and receive critical information from his doctor. Second, this concern "is based upon the simplistic assumption that trust implies only that physicians will do no harm. The fact is that many patients now want to trust that their physicians will stay with them and will not abandon them when the only way out of their suffering is to help them to die as they choose." Hall, *Final Act*, at 14.[16]

III. REGULATION OF PHYSICIAN-ASSISTED SUICIDE IS FEASIBLE AND WOULD BETTER SERVE PETITIONERS' INTEREST IN PREVENTING POTENTIAL ABUSE THAN THE CURRENT SECRET PRACTICE .

Although Petitioners and many of their supporting *amici* concede the compelling nature of the suffering of individual terminally ill patients such as those who brought these actions, *see, e.g., Vacco* Pet'r Br. at 19; *Glucksberg* Pet'r Br. at 16; U.S. *Glucksberg* Br. at 21, they nevertheless contend that such patients must be forced to endure intolerable suffering because there is no way to effectively regulate the practice of physician-assisted suicide to ensure that it is limited to such patients and only exercised voluntarily, *see Vacco* Pet'r Br. at 29-31; *Glucksberg* Pet'r Br. at 44-47.[17]

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16. Petitioners' further attempt to justify their criminal ban by contending that, once freed of the prohibition from intentional harm, medical providers might resort to encouraging physician-assisted suicide as a means of reducing health care costs, *see Vacco* Pet'r Br. at 29, ignores the far greater economic incentives providers have for reducing the enormous costs of life-sustaining treatment for the terminally ill. This argument can not, therefore, support the line Petitioners seek to draw.

17. The State of Washington, as well as *amici* States, also argue that holding that a categorical criminal prohibition of physician-assisted suicide puts an undue burden on the exercise of such rights would somehow limit each State's "broad range of discretion" to develop appropriate regulations in this

Medical decisions concerning physician-assisted suicide are, however, no more subject to error or abuse than other end-of-life decisions, such as refusal of life-sustaining treatment, which have been effectively regulated by States for more than two decades. Indeed, the risks involved in such decisions do not essentially differ from the numerous decisions that patients must make concerning procedures that involve a significant risk of mortality.[18]

Both statistical and anecdotal evidence indicate that the practice of physician-assisted suicide, although illegal in virtually all states, is prevalent throughout the United States.[19] Legal

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area. *Glucksberg* Pet'r Br. at 16; *see also id.* at 47-49; *Amici* States Br. at 27-30. To the contrary, however, it would plainly allow States to develop a variety of appropriate substantive and procedural regulatory standards, such as those discussed below.

18. In support of their contention that physician-assisted suicide can not be effectively regulated, Petitioner Vacco and various amici, *see, e.g., Vacco* Pet'r Br. at 24 n.14; AMA *Glucksberg* Br. at 11-12, also point to the 1991 Remmelink Study, which studied the effects of the de facto legalization of both physician-assisted suicide and voluntary euthanasia in the Netherlands. However, a review of that study and its 1996 successor reveals that such reliance is misplaced. Rather, as the authors of the most recent report conclude, their data simply "do not support the idea that physicians in the Netherlands are moving down a slippery slope" towards "less careful end-of-life decision making and . . . the gradual social acceptance of euthanasia performed for morally unacceptable reasons." P.J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699, 1705 (1996). To the contrary, the reports show that "Dutch physicians continue to practice physician-assisted dying only reluctantly and under compelling circumstances." Marcia Angell, *Euthanasia in the Netherlands -- Good News or Bad?*, 335 New Eng. J. Med. 1676, 1677 (1996).

19. *See, e.g.*, Back, *Physician-Assisted Suicide in Washington*, at 919 (12% of Washington physicians received requests for assistance in suicide and in nearly 25% of those requests, prescribed a potentially lethal drug); David J. Doukas et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055, 1058 (1995) (38% of the 250 practicing oncologists in Michigan had been asked to participate in physician-assisted suicide and 18% had done so); Emanuel, *Oncology Patients* at 1808 ("More than 50% of oncologists had received requests for euthanasia or

recognition and regulation of physician-assisted suicide would only foster the Petitioners' interest in ensuring that the practice is limited to appropriate circumstances and is done in a manner that minimizes any potential for abuse.[20]

A. State Regulation Of End-of-Life Decisions Is Already Well-Established.

Legalized physician-assisted suicide would not be the first instance of state regulation of important end-of-life decisions. To the contrary, virtually every jurisdiction in the United States has regulations governing both living wills and decisions concerning the withdrawal or withholding of life-sustaining treatment in the absence of advance patient directives. These regulations require medical professionals to make judgments similar to these involved

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physician-assisted suicide [and] 13.5% said they had participated in physician-assisted suicide"); Terri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 Archives Internal Med. 722, 725-26 (1993) (Rhode Island survey of 393 physicians concluding 18.9% had been asked to prescribe a lethal amount of sleeping pills and 13.3% did so at least once); Melinda A. Lee et al., *Legalizing Assisted Suicide -- Views of Physicians in Oregon*, 334 N. Eng. J. Med. 310, 313 (1996) (21% of Oregon physicians had been asked in the last year to provide physician-assisted suicide and 7% had done so); *see also* David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844 (1989). These studies most likely underestimate the extent of the practice in the United States because they depend upon self-reporting of an illegal act that can easily be kept secret and because other health care professionals, including nurses, also assist in suicides. *See* David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1374 (1996) (study of critical care nurses across the country concluding that 17% were asked to assist in a suicide or perform euthanasia and 16% had done so at least once).

20. Furthermore, studies of the attitudes of terminally ill patients suggest that it is the patients who are assumed to be most vulnerable, such as those with limited cognitive ability or lower income or education, who look with least favor on the option of physician-assisted suicide. *See, e.g.*, H.G. Koenig et al., *Attitudes of Elderly Patients and their Families toward Physician-Assisted Suicide*, 156 Archives of Internal Medicine 2240, 2247 (1996).

in physician-assisted suicide and demonstrate how procedural safeguards can ensure that patients make end-of-life decisions competently and voluntarily.

For example, health professionals and lawyers have implemented state laws concerning living wills for more than twenty years.[21] Patient declarations regarding the withdrawal of life support are currently regulated in forty-seven states, the District of Columbia and the Virgin Islands.[22] Regulation in most states

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21. For example, the California Natural Death Act (Cal. Health and Safety Code §§ 7185-7194.5) was enacted in 1976. In addition, since 1991, the federal Patient Self-Determination Act, 42 U.S.C. §§ 1395cc, 1396a (1994), has required health care providers to have written institutional policies regarding living wills and to document whether or not a patient has executed such an instrument. Such institutional policies often mandate the involvement of the hospital ethics committee to oversee the process and the decisions taken with regard to the execution and implementation of living wills.

22. Ala. Code §§ 22-8A-1 to -10; Alaska Stat. §§ 18.12.010 to 18.12.100; Ariz. Rev. Stat. Ann. §§ 36-3201to 36-3262; Ark. Code Ann. §§ 20-17-201 to-218; Cal. Health & Safety Code §§ 7185-7194.5; Colo. Rev. Stat. §§ 15-18-101 to -113; Conn. Gen. Stat. §§ 19a-570 to -580; Del. Code Ann. tit. 16, §§ 2501-2509; D.C. Code Ann. §§ 6-2421 to -2430; Fla. Stat Ann. §§ 765.101-765.401; Ga. Code Ann. §§ 31-32-1 to -12; Haw. Rev. Stat. §§ 327D-1 to 327D-27; Idaho Code §§ 39-4501 to -4509; 755 Ill. Comp. Stat. Ann. §§ 35/1 to 35/10; Ind. Code Ann. §§ 16-36-4-1 to -21; Iowa Code §§ 144A.1 to .12; Kan. Stat. Ann. §§ 65-28,101 to 65-28,109; Ky. Rev. Stat. Ann. §§ 311.621 to 311.644; La. Rev. Stat. Ann. §§ 40:1299.58.1 to 40:1299.58.10; Me. Rev. Stat. Ann., tit. 18-A, §§ 5-801 to -817; Md. Code Ann.., Health-Gen. I §§ 5-601 to 5-618; Minn. Stat. §§ 145B.01 to 145B.17; Miss. Code Ann. §§ 41-41-101 to -121; Mo. Ann. Stat. §§ 459.010 to 459.055; Mont. Code Ann. §§ 50-9-101 to -111, -201 to -206; Neb. Rev. Stat. Ann. §§ 20-401 to -416 and §§ 30-3401 to -3452; Nev. Rev. Stat. §§ 449.535 to 449.690; N.H. Rev. Stat. Ann. §§ 137-H:1 to H:16; N.J. Stat. Ann. § 26:2H-53 to 2H-78; N.M. Stat. Ann. §§ 24-7-1 to -11; N.C. Gen. Stat. §§ 90-320 to -322; N. D. Cent. Code §§ 23-06.4-01 to -14; Ohio Rev. Code Ann. §§ 1337.11 to 1337.17, 2133.01 to 2133.15; Okla. Stat. Ann. tit. 63, §§ 3101.01 to 3101.16; Or. Rev. Stat. §§ 127.505 to 127.660; 20 Pa. Cons. Stat. Ann. §§ 5401-5416; R.I. Gen. Laws §§ 23-4.10-1 to 23-4.10-12, 23-4.11-1 to 23-4.11-14; S.C. Code Ann. §§ 44-77-10 to -160; S.D. Codified Laws §§ 34-12D-1 to 34-12D-22; Tenn. Code Ann. §§ 32-11-101 to -112; Tex. Health & Safety Code Ann. §§ 672.001 to 672.021; Utah Code Ann. §§ 75-2-1101 to -1119; Vt. Stat. Ann. tit. 18, §§ 5251 to 5262; V.I. Code Ann. tit. 19, § 192; Va. Code Ann. §§ 54.1-2981 to -2993; Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.920; W. Va. Code §§ 16-30-1 to -13; Wis. Stat. Ann. §§ 154.01 to

follows a similar pattern. Declarants are restricted to individuals over the age of eighteen who are of "sound mind"[23] or "competent."[24] Further, all declarations must be signed and witnessed,[25] and the patient must have a "terminal," "incurable" or "irreversible" condition, or be "permanently unconscious," before the instructions may be followed.[26] Several other common procedural safeguards include: restrictions on who may act as a witness (*e.g.*, those who stand to benefit financially from the patient's death or those who are employed by the relevant medical facility are barred);[27] a mandatory second opinion as to the patient's

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154.15; Wyo. Stat. Ann. §§ 35-22-101 to -108. The three states that do not regulate living wills have all enacted "health care proxy statutes" which allow designated agents to make health care decisions, including the withdrawal of life support, whenever the patient is no longer able to make treatment decisions. *See* Mass. Gen. Laws Ann. ch. 201D, §§ 1-17; Mich. Comp. Laws §§ 700.496; N.Y. Pub. Health Law §§ 2980 to 2994.

23. *See, e.g.*, Cal. Health and Safety Code § 7186.5(a); Ohio Rev. Code § 1337.12(A)(1); N.H. Rev. Stat. Ann. § 137-H:3; 20 Pa. Cons. Stat. Ann. § 54.04(a).

24. *See, e.g.*, Colo. Rev. Stat. § 15-18-104; Fla. Stat. Ann. §§ 765.102(1), 765.302(1); Mo. Ann. Stat., § 459.015; Tex. Health & Safety Code § 672.003(a); Va. Code Ann. § 54.1-2983.

25. *See, e.g.*, Cal. Health & Safety Code § 7186.5(a); D.C. Code Ann. § 6-2422; Fla. Stat. Ann. § 765.302(1); Tex. Health & Safety Code § 672.003(b); Va. Code Ann. § 54.1-2983.

26. *See, e.g.*, Ark. Code Ann., § 20-17-202; Cal. Health & Safety Code §§ 7185.5(d), 7186.5(b); Conn. Gen. Stat. § 19a-575a; Fla. Stat. § 765.303; 20 Pa. Cons. Stat. Ann. § 5405(2); Va. Code Ann. § 54.1-2983; Wa. Rev. Code §§ 70.122.010, 70.122.030(1).

27. *See, e.g.*, Cal. Health & Safety Code § 7285.5(a); D.C. Code Ann., § 6-2422 (4); Ohio Rev. Code Ann., § 1337.12 (B); Tex. Health & Safety Code § 672.003(c); Wa. Rev. Code § 70.122.030(1).

condition;[28] and record-keeping requirements.[29]

B. Comprehensive Regulations For Physician-Assisted Suicide Have Already Been Promulgated.

Various comprehensive schemes for regulating physician-assisted suicide have already been developed. These include (*i*) the Oregon Death with Dignity Act, (*ii*) the Harvard model statute, so-called because several of its authors are affiliated with Harvard University, and (*iii*) the guidelines promulgated by the Bay Area Network of Ethics Committee ("BANEC").[30] These regulatory schemes draw on the previous extensive experience of health professionals and lawyers in making and regulating other end-of-life decisions. They include the following procedural safeguards:

- Those requesting physician-assisted suicide must be adults suffering from a terminal or intractable and unbearable illness. *See* Harvard Model § 3(a)(2); BANEC Gd. V.A(1); Or. Rev. Stat. § 127.805.

- The request must be voluntary (*i.e.*, free of undue

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28. *See, e.g.*, Cal. Health & Safety Code §7186.5(b); Colo. Rev. Stat. § 15-18-107; Fla. Code Ann. § 765.303(1); D.C. Code § 6-2422 (c); Kan. Stat. Ann. § 65-28, 103(c); Ohio Rev. Code § 1337.11(y); 20 Pa. Cons. Stat. Ann. § 5408.

29. *See, e.g.*, Cal. Health & Safety Code § 7189; Kan. Stat. Ann. § 65-28, 103 (b); Mo. Rev. Stat. §459.015(2); 20 Pa. Cons. Stat. Ann. § 5404 (D); Tex. Health & Safety Code § 672.003(e); Wa. Rev. Code § 70.122.030(1).

30. *See* Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800 to 127.995; Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) ("Harvard Model") (attached hereto as Appendix B); Bay Area Network of Ethics Committees (BANEC), *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill* (Sept. 1996) ("BANEC Gd.") (attached hereto as Appendix C).

influence), informed, and repeated on at least two occasions. *See* Harvard Model § 3(a)(3)(C), (D); BANEC Gd. V.A(4), F; Or. Rev. Stat. §§ 127.805, 127.830, 127.840.

- A second opinion in writing must be sought to confirm the diagnosis of the patient. *See* Harvard Model § 5(a); BANEC Gd. V.B; Or. Rev. Stat. § 127.820.

- A second opinion as to the mental state of the patient must be submitted in writing. Harvard Model § 5(b); BANEC Gd. V.B; Or. Rev. Stat. § 127.820. In particular, the second physician must confirm that the patient's judgment has not been distorted by clinical depression or other mental illness. *See* Harvard Model § 5(b); BANEC Gd. B; Or. Rev. Stat. § 127.825.[31]

- Patients must be informed of, and offered, all reasonable palliative care options. *See* Harvard Model § 4(a); BANEC Gd. V.C; Or. Rev. Stat. § 127.815.

- Patients must be informed of their diagnosis, prognosis, and the various benefits and burdens of the available medical options, including physician-assisted suicide. *See* Harvard Model § 5(d); BANEC Gd. V.E; Or. Rev. Stat. § 127.815.

- Patients must be counseled to consult with their family. *See* Harvard Model § 4(c); BANEC Gd. V.D; Or. Rev. Stat.

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31. Under the Oregon statute, whenever, in the opinion of the attending or consulting physician, a patient may be suffering from a mental disorder or depression causing impaired judgment, the patient must be referred for counseling and the person performing the counseling must determine that the patient is not suffering from such problems. *See* Or. Rev. Stat. § 127.825.

§ 127.835.

- Patients must be informed that they may consult a third party, *e.g.*, a social worker, or a hospital ethics committee. *See* Harvard Model § 4(b); BANEC Gd. V.D.

- The patient must execute a signed, witnessed request for physician-assisted suicide.[32] The witnesses must be individuals who do not stand to benefit from the patient's death and who are not affiliated with the relevant health care facility. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810. In certain cases (*e.g.*, if the patient is in a skilled nursing facility), the presence of a state-appointed witness is required. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810(4).

- The patient must be informed that he or she may revoke the request. *See* BANEC Gd. V.G; Or. Rev. Stat. § 127.845.

- All documentation, including the declaration, the opinion of the attending physician, and the second opinions, must be included in the patient's medical record. *See* Harvard Model §§ 4(d)(3), 5(c), 6 (does not include the patient's request); BANEC Gd. V.A-H; Or. Rev. Stat. § 127.855.

- Attending physicians must prepare detailed reports which are either filed with or made available to State health

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32. Model written forms can be found in BANEC Guidelines -- Attached Form #2 and Or. Rev. Stat. § 127.897. The Harvard Model has no equivalent provision and allows an oral request. However, the physician's discussion with the patient regarding the patient's diagnosis and prognosis and the benefits and burdens of the treatment options (including physician-assisted suicide) must be witnessed and either recorded on video or audio tape or transcribed and signed by the patient. Harvard Model § 4(d); *see also* BANEC Gd. V. E; Or. Rev. Stat. § 127.810.

officials.[33]

C. Regulation Of Physician-Assisted Suicide Is Just As Feasible As Regulation Of Other End-Of-Life Decisions.

Each of the key concepts involved in assessing the appropriateness of physician-assisted suicide has been used for years in making and regulating other end-of-life decisions by patients and their doctors. There is no basis for believing that such regulations could not similarly ensure that physician-assisted suicide is appropriately limited to terminally ill patients who have made their decisions competently, voluntarily and with the best available information concerning their medical condition and options.

1. Terminal Illness

Determinations of terminal illness have been used as a basis for end-of-life decisions for more than two decades and form part of the regulatory schemes of virtually all States, including Petitioners New York and Washington.[34] Thus, both physicians and hospital ethics committees have extensive experience in determining when a patient is terminally ill.

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33. For example, under the Harvard model statute, the attending physician must file a detailed report with the state Health Commissioner. *See* Harvard Model § 6. The Commissioner may review the reports and medical records in order to prepare an annual report on the operation and success of the statute. *See id.* § 9(d). The BANEC Guidelines propose the creation of a state registry which would be able to request, for review, the full medical records of all patients, including details of the hastened death. The registry would track complete demographic information and issue an annual report detailing its findings. *See* BANEC Gd. V.K.

34. *See, e.g.*, N.Y. Pub. Health Law § 2961(23); Wash. Rev. Code Ann. § 70.122.020(9).

Although the risk of misdiagnosis can never be entirely eliminated, a number of studies suggest that erroneous prognoses of the terminally ill tend to be overly optimistic. *See, e.g.*, Ronald S. Schonwetter et al., *Estimation of Survival Time in Terminal Cancer Patients: An Impedance to Hospice Admissions*, 6 Hospice J. 65 (1990); Lorna E. Forster et al., *Predicting Life Span For Applicants to Inpatient Hospice*, 148 Archives Internal Med. 2540, 2542 (1988). Moreover, even if an illness is misdiagnosed by a primary physician as "terminal," there are a number of subsequent safeguards and procedures which could reduce the risk of error before physician-assisted suicide would be permitted. For example, the Harvard model statute provides for a mandatory second opinion as to the severity of the patient's condition. Harvard Model § 5(a).

More importantly, legalization of physician-assisted suicide, in contrast to the current secret practice, would ensure that patients will make such decisions based on frank and full discussions with their doctors concerning their medical condition and options and that their doctors can freely consult with other medical professionals. Furthermore, because physician-assisted suicide will be limited to patients whose suffering is severe and untreatable, the risk of an overly pessimistic diagnosis must be weighed against the unendurable condition in which the patient might survive. In such circumstances, an overly optimistic prognosis may risk as severe harm to the patient as an overly pessimistic one. *Cf. Cruzan*, 497 U.S. at 320 (Brennan, J., dissenting) (an erroneous decision to keep alive a patient on life support is just as irrevocable as an erroneous decision to remove life support because the patient's "own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted").

2. Informed Consent

The requirement of informed consent is a concept familiar to all health care professionals as part of any decision to undergo medical treatment and is a well-established feature of the health law of both New York and Washington.[35] Because of the seriousness of the decision to elect physician-assisted suicide, additional safeguards can ensure that the patient has all of the medical information necessary to make her decision and that there is a sufficient record so that the adequacy of the information provided to the patient can be subject to review. For example, the Harvard model statute requires that the responsible physician shall:

> supply to and discuss with the patient all available medical information that is necessary to provide a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens.

Harvard Model § 4(d). This discussion must be witnessed by two individuals "at least one of whom . . . must not be affiliated with any person that is involved in the care of the patient, [or] . . . stand to benefit personally in any way from the patient's death." *Id.* § 4(d)(1). The medical discussion must be either recorded on video or audio tape or summarized in a document which the patient signs. *See id.* § 4(d)(3). The physician must inform the witnesses that

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35. *See* N.Y. Pub. Health Law § 2441 ("'Voluntary informed consent' means the legally effective knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion."); *Villanueva v. Harrington*, 906 P.2d 374, 376 (Wash. 1995).

they "may question the . . . physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed." *Id.* § 4(d)(2). In addition, the model statute mandates the involvement of at least three health care professionals at different points in the process (the primary physician, consulting physician and licensed psychiatrist, clinical psychologist or psychiatric social worker), all of whom will discuss the matter with the patient. Finally, the written opinion on the patient's competence must specifically address whether the patient's decision is "fully informed." *Id.* §§ 5(a), (b).

3. Voluntariness

Assessments of voluntariness are also a well-established aspect of existing schemes for regulating other end-of-life decisions. For example, most living will statutes include provisions intended to ensure that end-of-life decisions are made voluntarily, such as requirements that multiple witnesses be present at the time the living will is executed. *See supra.* Additional protections can ensure that individuals are not coerced into choosing physician-assisted suicide. For example, the Harvard model statute requires that the patient's request be made on separate occasions at least two weeks apart. Harvard Model § 3(a)(3)(D). In addition, a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient must make a written finding that the patient's judgment is "free of undue influence." *Id.* § 5(b).

4. Competence Or Capacity

Assessments of a patient's capacity to make a medical decision are also a common and well-established aspect of medical practice. Indeed, "[t]here appears . . . to be a developing consensus regarding the meaning of capacity in cases dealing with medical

decision making, including those concerning life-sustaining treatment. This consensus is toward accepting the meaning of capacity implied in the Restatement of Torts [§ 892A], namely the ability to appreciate the nature, extent, or probable consequences of the physician's conduct to which consent is given." 1 Alan Meisel, *The Right to Die* § 3.19, at 100 (2d ed. 1995).[36]

The Harvard model statute again suggests how states can adopt the general standards of competency to the special circumstances of terminally ill patients to ensure that decisions are not "the result of a distortion of the patient's judgment due to clinical depression or any other mental illness." Harvard Model § 3(a)(3)(A); *cf.* Martha Alys Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 Cal. L. Rev. 707 (1987) (proposing test for determining competency of patients who seek to hasten death). In order to ensure that the patient fully understands the nature of their decision, the Harvard model statute requires consultation with a licensed psychiatrist, clinical psychologist, or psychiatric social worker, who must provide a written opinion that the patient is not seeking physician-assisted suicide due to clinical depression or mental illness. Harvard Model § 5(b). Well-established criteria exist, such as prior mental illness, and the intensity and consistency of the symptoms, which allow psychiatrists to differentiate between clinical depression and mere feelings of sadness and grief. *See* Block, *Patient Requests*, at 2042.

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In short, all of the assessments that medical professionals would need to make to ensure that physician-assisted suicide is

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36. *See, e.g.*, N.Y. Pub. Health Law § 2980 (3) ("Capacity to make health care decisions' means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.").

limited to appropriate circumstances are currently being made by physicians in virtually all States -- including those of Petitioners themselves -- in connection with other, equally weighty end-of-life decisions. Numerous proposals have already been developed with extensive procedural protections to minimize the possibility of risk of error or abuse in aiding terminally ill, suffering patients to voluntarily hasten their own deaths. There is no justification, therefore, for a categorical criminal prohibition of the practice.

CONCLUSION

For the reasons stated above, *amici* urge this Court to affirm the decisions of the Courts of Appeals for the Second and Ninth Circuits.

December 10, 1996

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APPENDIX A[1]

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Rodney R. Bentz, M.D., M.A., private practice in pulmonary disease and critical care medicine for over 25 years; former Assistant Professor of Internal Medicine and Pulmonary Medicine, University of Michigan Medical Center; Master's Degree in medical ethics (thesis entitled "Beneficent Medical Care and Physician-

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1. The individual medical professionals do not necessarily represent the views of those organizations with which they are affiliated.

Assisted Suicide"); Member and Ethics Committee Member, Michigan State Medical Society; Chairman, Medical Ethics Committee, St. Joseph's Mercy Hospital; Member, Society for Bioethical Consultation; author of numerous publications regarding pulmonary and critical care medicine.

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Thomas F. Hornbein, M.D., Professor of Anaesthesiology, Physiology and Biophysics, University of Washington School of Medicine; Research Affiliate, Primate Center, University of Washington School of Medicine; Member and former President, Association of University Anaesthesiologists; Member and multiple committee-member, American Society of Anaesthesiologists; Editorial Board, *Journal of Applied Physiology*; author of nearly 150 publications regarding various aspects of respiration, ventilation and oxygenation.

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Michigan School of Public Health; Associate Professor of History, University of Michigan; Director, Program in Society and Medicine, University of Michigan Medical Center; Attending Physician, University of Michigan Medical Center; Member, Society for Heath and Human Values; author of over 50 publications regarding medical practice, history and values.

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Janet L. Mitchell, M.D., M.P.H., Chairperson, Department of Obstetrics and Gynecology, Interfaith Medical Center; Obstetrical Consultant, New York City Department of Health Bureau of Maternity Services and Family Planning, National Institutes of Health and Centers for Disease Control and Prevention; former Chief of Perinatology and Director of Special Prenatal Program for Chemically Dependent Women, Harlem Hospital Center; former Director of Ambulatory Perinatology, Boston City Hospital; author

of over 50 publications regarding substance abuse in pregnant women, HIV disease in women and infant and maternal mortality, including Chairperson on the Center for Substance Abuse Treatment panel that wrote the Treatment Improvement Protocols for Substance Using Pregnant Women.

David Orentlicher, M.D., J.D., Associate Professor of Law in Bioethics and Law, Fourteenth Amendment and Professional Responsibility, Indiana University School of Law; former Adjunct Assistant Professor of Medicine, Northwestern University Medical School; former Director, Division of Ethics Standards, and Ethics and Health Policy Counsel, American Medical Association; Member, American Law Institute; Editorial Advisory Board, *Food and Drug Law Journal*; Member, American Association of Bioethics; author of over 80 publications regarding legal and ethical issues in medicine, including physician-assisted death.

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Edward Pierce, M.D., retired family physician; Chairperson, Merian's Friends; former Michigan State Senator; former Mayor of the City of Ann Arbor, Michigan.

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publications regarding end stage renal disease.

Peter Safar, M.D., Distinguished Professor of Resuscitation Medicine and Endowed Chair in Anaesthesiology and Critical Care Medicine, University of Pittsburgh Medical Center; Founder and Fellow, American College of Critical Care Medicine and American College of Chest Physicians; Founder and former Director, Safar Center for Resuscitation Research; Founder, Departments of Anaesthesiology at National Cancer Institute (Lima, Peru), Baltimore City Hospitals, and University of Pittsburgh Medical Center; Founder, World Association for Disaster and Emergency Medicine; author of over 1,100 publications, including the first textbooks on Respiratory Therapy, Anaesthesiology and Emergency Medicine, and numerous articles and President's Commission studies regarding biomedical ethics and death.

Anthony L. Suchman, M.D., Associate Professor of Medicine and Psychiatry, University of Rochester School of Medicine & Dentistry; Executive Director of Highland PO, Inc.; Fellow, American College of Physicians; Charter Fellow and Senior Facilitator, American Academy for Physician and Patient; Member, managed care committees, Robert Wood Johnson Foundation, Fetzer Institute and the Society for General Internal Medicine; author of numerous publications regarding doctor-patient relationships and medical decision-making.

Griffith D. Thomas, M.D., J.D., practitioner, Anatomic, Clinical and Forensic Pathology; Medical Staff Member, Valley Presbyterian Hospital; Director, Valley Community Clinic; Los Angeles County Bar Association (Bioethics Committee, Subcommittee on Durable Power of Attorney, Subcommittee on AIDS, Subcommittee on Death and Dying); Founder Barristers Hospice/AIDS Project; Joint LACBA/LACMA Committee on Biomedical Ethics; author of several publications regarding AIDS.

Milton Viederman, M.D., Professor of Clinical Psychiatry, Cornell University Medical College; Lecturer in Psychiatry, Columbia College of Physicians and Surgeons; Director, Consultation-Liaison Service, and Attending Psychiatrist, New York Hospital; Adjunct Attending Physician, Memorial Hospital for Cancer & Allied Diseases; Associate Director, Columbia Psychoanalytic Center for Training and Research; Consultant, Rockefeller University Hospital; Life Fellow, American Psychiatric Association; Fellow and Member, Committee on Physician-Assisted Suicide, New York Academy of Medicine; Reviewer, *American Journal of Psychiatry*, *Hospital and Community Psychiatry*; author of nearly 70 publications regarding various aspects of psychiatry, the doctor-patient relationship, bioethics and medical decision-making.

Sidney H. Wanzer, M.D., Physician, Harvard University Health Services; Clinical Instructor in Medicine, Harvard Medical School; Preceptor for residents from Cambridge Hospital on ambulatory care medicine rotation; Member, Advisory Committee, Hemlock Society U.S.A.; author of several publications regarding the ethics and regulation of physician-assisted suicide, including the "Harvard Model statute."

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Peter M. Winter, M.D., Peter and Eva Safar Professor of Anaesthesiology and Critical Care Medicine and former Chairman, University of Pittsburgh School of Medicine; Visiting Professor of

Anaesthesiology at 14 medical schools across the United States; Anaesthesiologist-in-Chief, University Health Center Hospitals of Pittsburgh; Member, Advisory Committee and Managed Care Committee, Center for Medical Ethics, University of Pittsburgh School of Medicine; Member, American College of Chest Physicians, American Medical Association, New York Academy of Sciences; Founding Member, American Society of Critical Care Anaesthesiologists and Society of Critical Care Medicine; Chairman, Educational Advisory Board, Association of University Anaesthetists; Editorial Board, *Critical Care Medicine*; author of over 100 publications on critical care medicine, acute respiratory failure and anaesthetic agents.

APPENDIX B

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

SECTION 1. STATEMENT OF PURPOSE

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for continuing oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

SECTION 2. DEFINITIONS

As used in this Act,

(a) "Commissioner" means the Commissioner of the Department.

(b) "Department" means the Department of Public Health [or similar state agency].

(c) "Health care facility" means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.

(d) "Intractable and unbearable illness" means a bodily

disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.

(e) "Medical means of suicide" means medical substances or devices that the responsible physician prescribes for or supplies to a patient for the purpose of enabling the patient to end his or her own life. "Providing medical means of suicide" includes providing a prescription therefor.

(f) "Patient's medical record" means (1) in the case of a patient who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

(g) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

(h) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient.

(i) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

SECTION 3. AUTHORIZATION TO PROVIDE ASSISTANCE

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a

patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

(1) the patient is eighteen years of age or older;

(2) the patient has a terminal illness or an intractable and unbearable illness; and

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request

(A) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

(B) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

(C) has been made free of undue influence by any person; and

(D) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this Act may, if the patient so requests, be present and assist the patient

at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

SECTION 4. DISCUSSION WITH PATIENT AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's cares sufficiently to cause the patient to reconsider his or her request for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits

and burdens, all in accordance with the following procedures:

(1) at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (A) is not affiliated with any person that is involved in the care of the patient, and (B) does not stand to benefit personally in any way from the patient's death;

(2) the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information pursuant to this paragraph (d), and discussed pursuant to this paragraph (d); and

(3) the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:

(A) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or

(B) a written summary of the discussion that the patient reads and signs and that the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

SECTION 5. PROFESSIONAL CONSULTATION AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

SECTION 6. RECORDING AND REPORTING BY THE RESPONSIBLE PHYSICIAN

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

SECTION 7. ACTIONS BY PERSONS OTHER THAN THE RESPONSIBLE PHYSICIAN

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

SECTION 8. RECORD KEEPING BY THE DEPARTMENT

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(b) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation of this Act. Such report shall include, at a minimum, the following information:

(1) the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical

practice, that the responsible physician advised the patient were practicably available;

(2) the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;

(3) the patient's vital statistics, including county of residence, age, sex, race, and marital status;

(4) the type of medical insurance and name of insurer of the patient, if any:

(5) the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and

(6) the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

SECTION 9. ENFORCEMENT AND REPORTING BY THE DEPARTMENT

(a) The Commissioner shall enforce the provisions of this Act

and shall report to the Attorney General and the appropriate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and may by regulation require the submission of such information to the Department.

SECTION 10. CONFIDENTIALITY OF RECORDS AND REPORTS

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

SECTION 11. PROVIDER'S FREEDOM OF CONSCIENCE

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

SECTION 12. PATIENT'S FREEDOM FROM DISCRIMINATION

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or

entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

SECTION 13. LIABILITY

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to an individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

SECTION 14. CRIMINAL PENALTIES

In addition to any other civil, criminal, or disciplinary liability that he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].

APPENDIX C

BAY AREA NETWORK OF ETHICS COMMITTEES

BANEC-GENERATED GUIDELINES FOR
COMPREHENSIVE CARE OF THE TERMINALLY ILL

(NOTE: These guidelines are intended for use regardless of the patients' residence -- home, hospital, hospice, clinic, or extended care facility -- as they approach death.)

I. The ultimate responsibility for the care of the patient, pertaining to end-of-life decisions and treatments, resides with the patient's physician.

II. The primary care physician is qualified to provide appropriate care, with or without consultation, for the great majority of patients who are dying.

III. The care of patients experiencing "difficult deaths," those undergoing (in their judgment) intolerable or prolonged suffering as they die, or patients who are making complex and irreversible decisions about end-of-life (including the decision to hasten death), may fall out of the range of skills of many primary care physicians.

Hospice programs have extremely effective teams which provide medical care had help patients with their decisions about end-of-life treatments. Certain physicians in the medical community are also recognized to have special expertise in palliative, end-of-life care. For those patients who face difficult deaths, or those who are making complex and irreversible decisions about terminal care (including a request for physician aid in hastening their death), THE BANEC GUIDELINES URGE REFERRAL TO A HOSPICE PROGRAM AND/OR CONSULTATION WITH A PHYSICIAN EXPERIENCED IN

PALLIATIVE CARE (including, but not limited to, pain control). Many patients, given appropriate and skilled palliative end-of-life care, will withdraw their requests for a hastened death.

IV. At times, in spite of skilled physical, psychological, spiritual and social care, an adult, mentally competent and terminally ill patient will desire a physician's aid in hastening death.

V. These guidelines urge that, before a physician aids a patient to hasten his or her death, the following occur (with specific documentation in the patient's hospital chart and/or outpatient medical records):

(NOTE: No physician, nurse, physician-assistant, pharmacist, or other health care worker is required to participate in the act of hastening a patient's death, nor in the patient's evaluation for such an act. However, these guidelines recommend that participation practitioners who exclude themselves from such participation respond to a patient's request for a hastened death by advising that patient of his or her right to obtain consultation from other practitioners, and/or facilitating the transfer of care should the patient so request.)

Chart documentation should include:

A) The primary care physician's ascertaining of:

1) The terminal diagnosis (a reasonable certainty of death within six months provided the disease runs its expected course, ascertained by review of the medical records and pertinent history and physical examination).

2) An assessment to confirm that, in the best judgement of the physician, the patient is mentally competent and not suffering from a depression that impairs decision making capability. (IT IS HIGHLY RECOMMENDED THAT PHYSICIANS NOT EXPERIENCED WITH SUCH AN EVALUATION SEEK APPROPRIATE AID, WITH THEIR PATIENT'S CONSENT, FROM OTHER PRACTITIONERS IN THE MEDICAL, PSYCHOLOGICAL, OR SOCIAL SERVICES COMMUNITY.)

3) That high-quality palliative care, by hospice and/or a physician recognized to have expertise in palliative care, has been made accessible to the patient.

4) That, to the best of the physician's knowledge, the patient's choice to hasten death has been freely made, independent of financial, family, health insurance, or other coercion.

B) A second opinion to confirm the four points noted above by the primary care physician. These guidelines strongly recommend that the second opinion be obtained from a physician recognized to have expertise in palliative end-of-life care.

C) Documentation of the patient's evaluation by a hospice program and/or physician with palliative care expertise (this can coincide with the second opinion noted above). Documentation should also be made of the palliative-care recommendations resulting from this evaluation, and the ways in which they have or have not been followed.

Alternately, documentation should be made that the patient declines an evaluation for improved palliative care. These guidelines recommend that these patients sign a form (see

attached) to indicate an understanding that they have waived a medical evaluation that could offer care with significant potential for improving their quality of life as they die.

D) The patient has been counseled that a decision to hasten death should, if at all possible, be discussed in detail with family members, loved ones, and others who are likely to be significantly affected by this decision.

The patient has also been counseled that the hospital and hospice medical ethics committees are valuable and willing to discuss his/her care, and the decision to hasten death, with the patient and/or family.

E) A witnessed consent form should be signed by the patient (see example attached), to include full disclosure of the illness, the procedure to aid the patient in hastening death and the associated risks, and a statement that other medical options exist (including hospice care) that might provide further comfort without hastening death.

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or

adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

F) A second witnessed signature by the patient must be obtained, no sooner than 48 hours after the first signature.

G) Before aiding the patient in hastening death, there should be chart documentation of verbal counseling that the patient has the right, at any time, to change his or her mind and to return to care that includes the involvement of a hospice team or another physician experienced in palliative care.

H) Chart documentation that the physical process of hastening death was initiated and completed by the patient: These guidelines emphasize that the physician may aid the patient in the process of hastening death (i.e. by provision of oral or injectable medication, or the starting and maintaining of intravenous access), but it should be the patient's own physical effort that initiates and completes the process.

(NOTE: In the BANEC discussions of this document, a significant minority felt that section H draws an artificial mechanical boundary between a "patient initiated" hastened death and a physician's act of administration of drugs once other guideline recommendations have been met. However, since the 9th Circuit Court addressed only physician assisted suicide, the final BANEC guidelines reflect this limitation and refer only to a "patient initiated and completed" process.)

I) These guidelines emphasize that, although it is the patient who undertakes the proximate action that leads to the hastened death, a physician or the physician's designee responsible for the care of the patient should remain immediately and continuously available to the patient and family until death has occurred.

J) The cause of death on the death certificate should be listed as the underlying disease.

K) Reporting: These guidelines urge that a system similar to that of the California Tumor Registry (including the confidentiality of information) be established to which all cases of physician aid in the hastening of a patient's death be reported. This registry would be able to request, for review, the full medical records of the patient, including details of the hastened death. The registry should track complete demographic information and issue an annual report detailing its findings. This report should be accessible to the public.

It is also recommended that existing hospital, hospice and community clinic peer-review organizations include cases of aid in hastening deaths in their mandate of review.

This document is a blueprint for potential policy, to be used as deemed appropriate by individuals or organizations. The Bay Area Network of Ethics Committees provides a forum for open, independent discussion of ethical issues in healthcare. Opinions and guidelines proffered via BANEC are not necessarily representative of or endorsed by any individual or organization participating in BANEC discussions, and are non-binding in all cases.

FORM #1: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

DOCUMENTATION OF OFFER OF CONSULTATION
AND SERVICES BY HOSPICE OR OTHER
PALLIATIVE CARE EXPERT

NAME:_____

My physician, _____, has recommended that I be evaluated by a hospice program and/or another physician, both of which have special expertise in controlling the emotional, spiritual and physical suffering that can be associated with dying. It is my understanding that hospice programs and such physicians can provide the optimal treatment for terminally ill patients such as myself, and that such treatment might include improved treatment for the pain associated with my illness, treatment and counseling for possible depression or other psychological or social issues, or other problems related to my condition. I further understand that while such treatments will not cure my condition or significantly extend my life, they do have the potential to improve my quality of life. It has been explained to me that a consultation with hospice is readily available to me, and that hospices can make arrangements that will not place additional financial burdens on myself or my family while they provide such services.

After due consideration of this information and offer of referrals, I hereby certify that:

- ☐ I decline the recommendation of a consultation with hospice personnel or physician; or
- ☐ I have accepted the referral and have consulted with (check one or more):

- ☐ Hospice representatives
- ☐ Another physician as referred to by my primary physician
- ☐ Other: _____

_____ _____
Signature of patient Date

_____ _____
Signature of witness Date

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients In a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

_____ _____
Signature of primary physician Date

_____ _____
Signature of translator (if applicable) Date

FORM 2: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

INFORMED CONSENT-- REQUEST FOR
PHYSICIAN ASSISTED DEATH

Patient's name: _____

I, the above-named patient, being of sound mind, have of my own free will and in consultation with my physician and others close to me, decided that it is my desire to end my life. I hereby certify that:

I am an adult resident of the State of California;

I believe, and my physicians agree, that I am mentally competent to make decisions regarding my life and death;

I have a confirmed terminal diagnosis with a reasonable prediction that, if the disease runs its expected course, I will die within six months of this date;

I am making this choice to hasten death of my own free will and have not been convinced or coerced to do so by any other persons or party, including any insurer or payor involved in the finances of my health care;

I have been offered full use of medical and hospice services and expertise for the improvement of my condition and quality of life, including management of my pain and discomfort; and have either availed myself of such consultations or have declined to do so;

I have also been offered consultation with an ethics committee of a hospice or hospitals and have or have not undertaken this consultation in accordance with my best judgement;

I have, in accordance with my best judgment, discussed (or chosen not to discuss) this final decision with any members of my family or others who will be affected by my death;

I have discussed the process to be utilized to hasten my death, its risks, and alternatives, and have chosen this method as my preferred means of ending my life;

I retain the right at any time to change my mind and withdraw my request to die. I understand that all other options for care, including hospice and other measures that are likely to make me more comfortable, continue to be available to me at all times.

First request: _____
Signature

Date:_____ Time:_____

Second request: _____
Signature

Date:_____ Time:_____
(Must be 48 hours from first request)

Signature of witnesses of patient's first signature: (NOTE: The selection of witness is in accordance with the regulations now established for the signing of a Durable Power of Attorney for Health Care Decisions).

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Signature of witness of patient's second signature:

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Name and signature(s) of translator (if applicable):_____
Date: _____ Time: _____

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses

who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

FORM 3: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

REPORT OF A PHYSICIAN-ASSISTED DEATH
(To be completed by the patient's primary physician)

(NOTE: All cases of assisted death should be reported to an appropriate organization. Until such time as an official reporting entity has been established, the BANEC guidelines recommend reporting to the local Health Department, hospital or hospice ethics committee, or an established peer review or quality assurance committee.)

This information will be held confidential and will be reviewed for compliance with recommended standards of practice only. It is hereby agreed that the patient's complete medical records may be requested by such a review committee, and I hereby agree to provide these records if so requested.

Patient name (or identifying code): _____
Patient's date of birth: _____ Age: _____ Sex: _____
Ethnicity: _____
Physician: _____
Patient's diagnosis: _____
Second physician who confirmed terminal diagnosis: _____
Date of death: _____
Location of death: (Institution/home/or?): _____
Physician's relation to patient (check one):

- ☐ I have been the patient's primary physician for ____ months/yrs.
- ☐ Patient was referred to me to deal with the illness/symptoms which led to the request for hastened death. Date of referral: __

☐ I believe patient was referred to me specifically regarding the hastening of death. Date of referral: _____

First witnessed request for a hastened death:
Date: _____ Time: _____

Second witnessed request for a hastened death:
Date: _____ Time: _____

Diagnosis and symptoms leading to patient's request: _____

Was patient referred for palliative care/hospice consultation:
☐ Yes ☐ No

Did the patient accept this consultation: ☐ Yes ☐ No
If Yes: Date of consultation: _____
By whom: _____
Outcome: _____

Please attach copies of signed forms:
1) Documentation of Offer of Consultation and Services by Hospice or Other Palliative Care Expert.
2) Informed Consent for Physician Assisted Death.
3) Physician Checklist in Assisted Death Cases.

Location of patient's medical records: _____

Mode of assisted dying utilized: _____

Other comments (use other side of form and additional pages as needed).

FORM #4: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

PHYSICIAN CHECKLIST IN ASSISTED DEATH CASES
(to be completed before the hastening of a patient

Patient's name: _____
Physician's name: _____

Prior to assisting in the death of a patient, please confirm the following:

☐ The patient is an adult resident of California.
☐ As the patient's physician, I am well aware of the patient's medical history, condition, diagnosis and prognosis.
☐ The patient's condition is terminal, with death otherwise expected to occur within six months of this date.
☐ A second physician has confirmed this terminal diagnosis.
☐ The patient is mentally competent and able to exercise rational thought processes in making decisions regarding their health care.
☐ High-quality palliative care, by hospice and/or physicians qualified to provide such care, has been offered to the patient, with full understanding that such care might result in an improved quality of life in the patient's remaining days.
☐ If such care has been refused by patient, such refusal has been documented by signed consent form.
☐ To the best of the physician's knowledge, the patient's choice to die has been freely made, independent of financial, family, health insurance, or other sources of coercion.
☐ The patient has been offered consultation with an ethics committee.

- ☐ The patient has been offered counseling by psychiatrist, therapist, social service worker, clergy or other.
- ☐ The patient has been counseled to discuss his/her decision with any family members, loved ones, or others who will be affected by this decision.
- ☐ The patient has made the required two signed, witnessed requests, at least 48 hours apart, for a hastened death.
- ☐ The patient has been offered appropriate means by ending his/her life, with full disclosure of the process, pros and cons of each, and has made an informed choice of which intervention will be utilized.
- ☐ At the time of the procedure, the patient is still competent, has made a third, final request, with witness(es) present, and has been advised that the procedure may be halted at any time upon the patient's request, with a return to optimal palliative care as an option.
- ☐ A healthcare professional (physician or nurse) with expertise in this area has been identified who will remain immediately and continuously available to assure that distressing symptoms are minimized via appropriate palliative means.

Following death, the usual confirmation and reporting requirements are in effect, with the addition of the reporting form for physician-assisted death.

NARRATIVE SECTION (OPTIONAL): PLEASE UTILIZE THE BACK OF THIS FORM AND/OR ADDITIONAL PAGES TO ADD ANY COMMENTS DEEMED APPROPRIATE REGARDING THIS PATIENT'S CASE.

_____ _____

Physician's signature Date

(54) (52)

Nos. 95-1858, 96-110

Supreme Court, U.S.
FILED
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON and CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF OF 36 RELIGIOUS ORGANIZATIONS, LEADERS AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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38 pp

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The American Humanist Association
The Board of Directors of The Society for Humanistic Judaism
The Cathar Church
The Congress of Secular Jewish Organizations
The Episcopal Diocese of Newark
The Unitarian Universalist Association
Doctor Robert S. Alley
The Reverend John R. Brooke
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INTEREST OF THE AMICI*

Amici are a diverse array of religious organizations, leaders, and scholars as well as advocates of religious liberty.[1] They have in common their dedication to the personal liberties and religious freedoms of all Americans as well as their concern for the plight of the terminally ill. Many of the individual *amici* counsel and comfort terminally ill people, and are thus familiar with their physical, emotional, and spiritual suffering and their struggle over the intensely personal decision to hasten an inevitable death. This decision implicates issues of great spiritual significance — issues that are not viewed in the same manner by all religious denominations or their adherents.

The interest of *amici* in these cases is to ensure that terminally ill Americans of all faiths are free to make decisions about the time, place, and manner of death that reflect their personal understanding of life's meaning, reduce the suffering of their bodies and their minds, and conform to their own ethical and spiritual values. While the government may properly regulate this choice to assure that it is truly voluntary and informed, the government may not proscribe the choice altogether, which would undermine the interests protected by the Free Exercise and Establishment Clauses of the First Amendment as well as the liberty component of the Fourteenth Amendment's Due Process Clause.

SUMMARY OF ARGUMENT

The right of a competent, terminally ill individual to end his or her life with the aid of a physician is one of the most important liberties protected by the Due Process Clause. That much is clear from *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), in which this Court endorsed the second Justice Harlan's vision of the liberty guaranteed by the Due Process Clause. Justice

---

* Counsel for both petitioners and respondents have consented to the filing of this brief *amici curiae*. Their consents are on file with the Clerk of the Court.

[1] *Amici* are described in greater detail in the Appendix to this brief.

Harlan's analysis, articulated most forcefully in his dissenting opinion in *Poe v. Ullman,* 367 U.S. 497, 543 (1961), requires courts — using "a reasonable and sensitive judgment" — to determine where, along the "rational continuum" of liberties from the most insignificant to the most fundamental, a particular interest lies. In making these judgments, courts should consider not only the liberties guaranteed by the text of the Constitution, but also the "purposes of those guarantees and . . . the reasons for their statement by the Framers." *Id.*

Amici urge that physician-assisted suicide is one of the most important liberties protected by the Due Process Clause, implicating as it does "the right to define one's own concept of . . . the mystery of human life." *Casey,* 505 U.S. at 851. Our long tradition of individual religious liberty and government noninterference with religious decisions, exemplified by the religion clauses of the First Amendment, serves to confirm that the "perplexing question" of physician-assisted suicide, with its "unusually strong moral and ethical overtones," *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261, 277 (1990), is an intimate, personal, and ultimately spiritual decision appropriately reserved to the individual's own conscience.

The purposes and reasons behind the Free Exercise Clause bear this out. The many diverse religious faiths represented in this country have many diverse views on the theological and moral propriety of physician-assisted suicide. Some religious denominations absolutely oppose physician-assisted suicide in all instances. Others, while stating no formal church position, have taken the position that an individual's decisions about death should be honored. Still others affirmatively support "the right to self-determination in dying." In the light of this diversity of religious views on the subject, the Due Process Clause's liberty guarantee should be understood to protect a competent, terminally ill adult's decision to end his or her life (or not) with the aid of a physician, just as the Free Exercise Clause protects an individual's right "to maintain theories of life and of death and of the hereafter." *United States v. Ballard,* 322 U.S. 78, 86 (1944).

Similarly, because the common-law's historical bans upon suicide are rooted in the incorporation of Roman Catholic canon law into the English common law, laws banning physician-assisted suicide raise serious Establishment Clause concerns. Laws that endorse one religious view over others, and have overtly religious purposes, are irreconcilable with the values underlying the Establishment Clause. *Lee v. Weisman,* 505 U.S. 577, 587-88 (1992); *Edwards v. Aguilard,* 482 U.S. 578, 592-93 (1987).

Finally, the Washington and New York bans upon physician-assisted suicide cannot survive the "particularly careful scrutiny" — that is, strict scrutiny — required by the Due Process Clause. *Casey,* 505 U.S. at 848-51. While state regulations designed to assure competence and voluntariness might be appropriate, these states' total bans upon this right are not the least restrictive means for furthering any compelling state interest.

ARGUMENT

This Court has endorsed the second Justice Harlan's vision of the substantive liberty guarantee of the Fourteenth Amendment's Due Process Clause. *See, e.g., Planned Parenthood v. Casey,* 505 U.S. 833 (1992). Justice Harlan recognized that the Due Process Clause requires courts to balance, carefully, the two primary — yet often conflicting — aspirations of a free society: the "liberty of the individual," on the one hand, and "the demands of organized society," on the other. *Poe v. Ullman,* 367 U.S. 497, 542 (1961) (Harlan, J., dissenting); *see also Casey,* 505 U.S. at 850; *Rochin v. California,* 342 U.S. 165, 171-72 (1952).[2]

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[2] This accommodation of individual and state interests allows for a wide range of legitimate regulation. Only as the burden imposed on a protected right becomes increasingly direct and substantial must the asserted state interest be strong and the regulation narrowly tailored to serve that interest. Accordingly, although all infringements of protected liberties are subject to a careful balancing of the individual's interest against the government's interest, strict scrutiny applies only when the government unduly burdens or proscribes a protected right. *Planned*

The end result of this balancing is clear in these cases: A competent, terminally ill person's ability to choose to hasten his or her death is a constitutionally protected "liberty of the individual," which is derived not only from the "liberty" component of the Due Process Clause but also from the religion clauses of the First Amendment. The "demands of organized society" do not justify the absolute bans imposed on this liberty by Washington and New York.

I. THE WASHINGTON AND NEW YORK BANS ON PHYSICIAN-ASSISTED SUICIDE BURDEN CORE LIBERTY INTERESTS PROTECTED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT AND THE RELIGION CLAUSES OF THE FIRST AMENDMENT

The term "liberty" in the Fourteenth Amendment's Due Process Clause is, admittedly, broad, encompassing every "liberty" from the most insignificant to the most fundamental. *See Poe*, 367 U.S. at 543 (Harlan, J., dissenting) (observing that liberty encompasses, at a minimum, "freedom from all substantial arbitrary impositions and purposeless restraints") (citing cases). As this Court recently reiterated in *Casey*, it is the task of judges, using "'a reasonable and sensitive judgment,'" to determine where along that "'rational continuum'" a particular liberty lies. 505 U.S. at 848 (quoting *Poe*, 367 U.S. at 543 (Harlan, J., dissenting)). The more fundamental the liberty interest, the more "careful scrutiny" must be given "the state needs asserted to justify [its] abridgement." *Poe*, 367 U.S. at 543 (Harlan, J., dissenting).

Parenthood v. Casey, 505 U.S. 833, 873-75 (1992); *Poe v. Ullman*, 367 U.S. 497, 548-49 (1961) (Harlan, J., dissenting); *see generally* Note, *Who Decides If There Is "Triumph in the Ultimate Agony?" Constitutional Theory and the Emerging Right To Die with Dignity*, 37 Wm. & Mary L. Rev. 827 (1996) (providing an extended analysis of Justice Harlan's approach as applied to physician-assisted suicide).

As Justice Harlan explained, in assessing whether and to what extent an asserted liberty interest merits constitutional protection, the courts must

> hav[e] regard to what history teaches are the traditions from which [the asserted interest] developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound.

Id. at 542. It is thus clear that courts are not precluded from recognizing even "an apparently novel claim" of a liberty interest, so long as the claim "depend[s] on grounds which follow from well-accepted principles and criteria." *Id.* at 544. In other words, the newly recognized liberty interest must "take 'its place in relation to what went before and further [cut] a channel for what is to come.'" *Id.* (quoting *Irvine v. California*, 347 U.S. 128, 147 (1954) (Frankfurter, J., dissenting)).

The liberties secured by the Bill of Rights necessarily qualify as "well-accepted principles," *Poe*, 367 U.S. at 543-44 (Harlan, J., dissenting), but the "liberty" embraced by the Fourteenth Amendment is broader than the mere text of those guarantees. "[I]t is the purposes of those guarantees and not their text, the reasons for their statement by the Framers and not the statement itself, . . . which have led to their present status in the compendious notion of 'liberty' embraced in the Fourteenth Amendment." *Id.* at 544 (Harlan, J., dissenting); *see also Palko v. Connecticut*, 302 U.S. 319, 324-27 (1937); *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 (1938).

As we show below, a terminally ill individual's ability to choose physician-assisted suicide "follow[s] from well-accepted principles and criteria," *Poe*, 367 U.S. at 544 (Harlan, J., dissenting), which derive both from the First Amendment's protection of religious freedom and from the Fourteenth Amendment's proscription of undue government interference in intimate, personal, and spiritual decisions.

A. The Interests Reflected In The Free Exercise Clause And The Liberty Component Of The Due Process Clause Establish That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty

1. Religious Organizations And Religious Leaders Have Taken A Wide Array Of Positions On The Morality Of Physician-Assisted Suicide

It should be emphasized at the outset that there is "no monolithic 'religious' position on the question of the morality or legality" of assisted suicide. G. Larue, *Playing God — 50 Religions' Views on Your Right to Die* 8 (1996); Campbell, *Religious Ethics and Active Euthanasia in a Pluralistic Society*, 2 Kennedy Inst. of Ethics J. 253, 253-54 (1992).[3] Rather, a "diversity of religious argumentation" exists about whether an individual may morally and ethically choose physician-assisted suicide. Campbell, 2 Kennedy Inst. of Ethics J. at 254.[4] The controversy surrounding physician-assisted suicide is, therefore, not merely "a clash of religious versus secular ethics." *Id.* Indeed, the intense debate over this issue — both among and within religious denominations — underscores that assisted suicide is, for many people, a religious question.[5]

---

[3] *See also* Note, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 Geo. L.J. 589, 596-601 (1996).

[4] Religious communities are also debating whether the term "suicide" should properly be used to refer to the informed and voluntary decision of a competent, terminally ill individual to hasten death with physician assistance. *See Compassion in Dying v. Washington*, 79 F.3d 790, 808 (9th Cir.) (*en banc*), *cert. granted*, 117 S. Ct. 37 (1996).

[5] Even within religious denominations that institutionally oppose physician-assisted suicide, many of their members may personally hold a different view, which they believe to be consistent with their own religious beliefs. *See* G. Larue, *Playing God — 50 Religions' Views on Your Right to Die* 8 (1996); Campbell, *Religious Ethics and Active Euthanasia in a Pluralistic Society*, 2 Kennedy Inst. of Ethics J. 253, 255-56 (1992) (citing a study finding that 70-80% of those affiliated with the major religions supported physician-assisted suicide).

The Roman Catholic Church, to be sure, has been "the sternest, most vigilant, and no doubt most effective opponent of euthanasia." R. Dworkin, *Life's Dominion* 195 (1993). Several other Christian denominations — but by no means all of them — have adopted "official" church positions against the morality of physician-assisted suicide. *See generally* G. Larue, *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right-to-Die* 26-117 (1985) (surveying various Christian denominations). Those Christian denominations that oppose physician-assisted suicide do so on two theological grounds: first, that physician-assisted suicide violates the Commandment that "thou shalt not kill," and second, "'that suffering is often sent by God for the remission of sins and the salvation of our souls; so if God has sent someone pain which cannot be alleviated by normal means (pain-killer shots, etc.), we must resign ourselves in the knowledge that this pain is necessary and inevitable.'" *Id.* at 55-56 (quoting Russian Orthodox Archpriest A. Mileant). It is thus acknowledged, even by opponents of physician-assisted suicide, that the suffering of terminally ill people has a spiritual dimension.[6]

These are not the only religious positions, however, on whether the terminally ill may choose to hasten death with physician assistance. The Episcopal Church, for instance, "has not formulated and published any official position on the questions surrounding euthanasia," explaining that to do so would "presuppos[e] a kind of authority of theological teaching and writing which is not relevant in the Episcopal Church." G.

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[6] *See* Campbell, 2 Kennedy Inst. of Ethics J. at 268-69 (quoting the Catholic teaching that "'suffering during the last moments of life . . . is in fact a sharing in Christ's passion'"); Episcopal Diocese of Washington, D.C., Committee on Medical Ethics, *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians? Perspectives to Consider* 12-13 (1996) (noting Christian views of the spiritual significance of suffering).

Larue, *Euthanasia and Religion, supra,* at 58 (quotation omitted). *Amicus* Episcopal Diocese of Newark thus appointed a Task Force on Assisted Suicide to study the issue in conjunction with the teachings of the Episcopal Church. The Task Force concluded that physician-assisted suicide "can be theologically and ethically justified" when a terminally ill person makes a voluntary and informed choice after all reasonable means of ameliorating his or her suffering have been exhausted.[7]

The United Church of Christ, the United Methodist Church, and the Presbyterian Church, among others, likewise have not adopted any formal position on physician-assisted suicide. A number of these denominations have taken the position more generally, however, that "basic Christian respect for persons demands that a person's decisions about death be honored in most instances."[8] These denominations encourage their members to offer compassion and understanding — rather than moral absolutes — to terminally ill individuals who are faced with the difficult choice whether to end their own lives.[9] In accordance with this teaching, the Pacific Northwest Conference of the United Methodist Church supported Washington Initiative 119, which would have recognized a right to physician-assisted suicide

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[7] Episcopal Diocese of Newark Task Force on Assisted Suicide, *Report* 9 (1996).

[8] Presbyterian Church (U.S.A.), Christian Faith and Life Area, Congregational Ministries Division, *In Life and Death We Belong to God: Euthanasia, Assisted Suicide, and End-of-Life Issues* 47 (1995) (citing 195th General Assembly position on "The Covenant of Life and the Caring Community" (1983)); *see also* United Church of Christ, The Council for Health and Human Service Ministries, *Making End-of-Life Decisions: United Church of Christ Perspectives* 24 (1993) (supporting "the right and responsibility of individuals to choose their own destiny" as well as "the rights of individuals, their designees and their families to make decisions regarding human death and dying").

[9] *See* United Church of Christ, *Making End-of-Life Decisions* at 24; United Methodist Church, *Book of Resolutions* 144 (1992).

in some circumstances. Campbell, 2 Kennedy Inst. of Ethics J. at 261.

The reformed and humanistic branches of Judaism also teach sympathy, understanding, and respect for those who choose assistance in hastening death. *See* G. Larue, *Playing God, supra,* at 62-65. Some Jewish organizations, including two of the *amici* here, take the position that a competent, terminally ill adult has the right to voluntarily hasten death with the aid of a physician. *See id.* at 64-66; *see also id.* at 56 (reprinting rabbi's statement with respect to Washington Initiative 119 that "[s]ometimes in a medical setting human freedom needs to be exercised resolutely to bring life to an end").

Still other religions have taken more formal institutional positions supporting the right to physician-assisted suicide. The General Assembly of *amicus* Unitarian Universalist Association supports "the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths."[10] *Amicus* Cathar Church, which is Evangelical in doctrine and has some similarity to the Amish and Mennonites, has taught for several centuries that decisions regarding the time and manner of death are matters of individual conscience best left to the individual and his or her God. Many Eastern religions also support a choice of physician-assisted suicide in certain circumstances. *See* Note, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life,* 84 Geo. L.J. 589, 597 (1996).

As the foregoing discussion demonstrates, the religious community is sharply divided, on theological and ethical grounds, as to the propriety of physician-assisted suicide. This confirms the correctness of this Court's observation in *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261, 277 (1990), that "all

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[10] General Assembly of the Unitarian Universalist Association of Congregations, *The Right to Die with Dignity* (1988).

agree" that an individual's decision to hasten death "is a perplexing question with unusually strong moral and ethical overtones." The Washington and New York statutes, however, dictate only one answer to that "perplexing question" to persons of all religious faiths.

2. A Terminally Ill Person's Decision To Hasten Death Is The Sort Of Personal, Intimate, Often Spiritual Decision To Which The First And Fourteenth Amendments Afford Protection

This Court has recognized in many diverse contexts that each individual should be allowed to define for himself or herself what constitutes a meaningful existence. The Due Process Clause has thus been held to protect "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education." *Casey*, 505 U.S. at 851. Similarly, the First Amendment freedoms have been recognized to occupy a "preferred position in our basic [constitutional] scheme," *Prince v. Massachusetts*, 321 U.S. 158, 164-65 (1944) because "under their shield many types of life, character, opinion and belief can develop unmolested and unobstructed." *Cantwell v. Connecticut*, 310 U.S. 296, 310 (1940).[11] At the heart of individual liberty, therefore, is "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851; *see generally Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("The makers of our Constitution . . . recognized the significance of man's spiritual nature . . . [and] knew that only a part of the pain,

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[11] *See also Doe v. Bolton*, 410 U.S. 179, 211 (1973) (Douglas, J., concurring) (recognizing the importance of preserving an individual's "autonomous control over the development and expression of one's intellect, interests, tastes, and personality"); Heymann & Barzelay, *The Forest and the Trees:* Roe v. Wade *& Its Critics*, 53 B.U. L. Rev. 765, 773 (1973) (noting "[t]he similarity of the protected rights in the areas of marriage, procreation and child rearing to the expressly protected rights in the areas of religion").

pleasure, and satisfactions of life are to be found in material things.").

A terminally ill person's decision to hasten death is a deeply personal, intimate, and often spiritual one, which is made only after solemn reflection, meditation, or prayer, and after consultation with doctors, family, and clergy.[12] It is a decision that raises "profound issues of human meaning and purpose, of identity and destiny" — issues that "strike to the very core of our being and integrity as persons." Campbell, 2 Kennedy Inst. of Ethics J. at 275; *see Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting) ("[o]ur ethical tradition has long regarded an appreciation of mortality as essential to understanding life's significance"). We frequently turn to religion when we are confronted by these sorts of issues: people "expect from the various religions answers to the riddles of the human condition: . . . What is the meaning and purpose of our lives? . . . What are death, judgment, and retribution after death?" *United States v. Seeger*, 380 U.S. 163, 182 (1965). Indeed, "not much may be said with confidence about death unless it is said from faith." *Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting).

It has thus been recognized that "religion lies at the very heart of" a terminally ill person's decision whether to hasten death. Note, 84 Geo. L.J. at 589.[13] The decision implicates attitudes

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[12] *See, e.g.*, Presbyterian Church (U.S.A.), *In Life and Death We Belong to God* at 43 (the decision to commit physician-assisted suicide should be made "thoughtfully and prayerfully, in collaboration with knowledgeable persons not emotionally captured by the situation"); G. Larue, *Euthanasia and Religion: A Survey of The Attitudes of World Religions to the Right-to-Die* 87 (1985) (quoting the United Methodist Church General Council's 1980 statement on Death With Dignity as recognizing the "agonizing personal and moral decisions faced by the dying, their physicians, their families, and their friends").

[13] *See* United Church of Christ, *Making End-of-Life Decisions* at 5 (noting the "intricacies of religious, medical, social, and emotional factors" in each case of terminal illness).

that, for many, are deeply rooted in their religious faith, including attitudes about self-definition, self-determination, and suffering.

Many individuals view their decisions about matters of personal "identity and destiny" as inherently religious ones. As one Protestant religious leader has put it, "the Christ experience is nothing less than our call to be who we are," so "I worship . . . Jesus when I claim my own being and live it out courageously."[14] A number of religious organizations have recognized that dying and death provide terminally ill individuals with a final opportunity to "claim [their] own being," consistent with their own philosophical, ethical, and spiritual attitudes about "human meaning and purpose." *See* Campbell, 2 Kennedy Inst. of Ethics J. at 275 ("our concern about dying well is integral to an understanding of how we might live a rich, meaningful life").[15] For example, "[s]ome persons in terminal conditions long for death as a means of being embraced by the divine," and thus may seek a voluntarily hastened death as a means of "profoundly exercis[ing] their faith when that may be the most meaningful act of creation available to them." G. Larue, *Playing God, supra* at 396 (reprinting report of Greater Seattle Council of Churches). Other terminally ill persons may decide that continuing to exist only with a body racked by pain, or a mind numbed by sedatives, strips them of their personhood. Still others may not want to be remembered in their present condition

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[14] Bishop J.S. Spong, *Rescuing the Bible from Fundamentalism: A Bishop Rethinks the Meaning of Scripture* 242 (1991).

[15] *See* United Church of Christ, *Making End-of-Life Decisions* at 5 (1993) ("The responsibility for life and death is a sacred one, and God calls on us to face up to our freedom of choice."); Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 21 (noting the view that "Christians have distinctive and compelling reasons for taking these claims of autonomy with great seriousness," because "[w]e are created in the image and likeness of God (Genesis 1: 26-37)" and "[a]n essential part of that image is our ability to make free choices").

"after [their] death by those whose opinions mattered to [them]." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting).[16]

There is a spiritual dimension, as well, to individuals' attitudes toward suffering and whether to seek final relief from suffering. With respect to a similarly difficult and intimate issue, this Court observed in *Casey* that the "suffering" endured by a pregnant woman — ranging from "anxieties, to physical constraints, to pain that only she must bear" — is "too intimate and personal for the State to insist" that she continue her pregnancy to term. *Casey*, 505 U.S. at 852. A woman's decision whether to continue or end a pregnancy must, therefore, "be shaped to a large extent on her own conception of her spiritual imperatives." *Id.* The same logic applies to decisions to end one's "suffering" from a terminal illness by hastening one's death; few decisions are more "intimate and personal," and few are more shaped by

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[16] Contrary to the claims of some other religious *amici* (*see, e.g.*, National Catholic Office & Knights of Columbus Br. 4; United States Catholic Conference *et al.* Br. 13-15), physician-assisted suicide may be inextricably intertwined with a terminally ill person's interest in pursuing a meaningful life. The fear of a painful or undignified death may hinder terminally ill individuals from resolving the unsettled aspects of their lives in a meaningful fashion. If such individuals are assured that they may choose the time, place and manner of their death, they are freed to live out their remaining days in a personally meaningful fashion and to come to peace with themselves, with others, and with their God. *See, e.g.*, Quill, Commentary, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991) (describing a woman whose fear of a "lingering death" was interfering with her ability to get "the most out of the time she had left"). This is precisely why durable powers of attorney and living wills are recognized and enforced: people benefit in life from knowing that their wishes will be respected at and after death. Stacy, *Death, Privacy, and the Free Exercise of Religion*, 77 Corn. L. Rev. 490, 535 (1992); United Church of Christ, *Making End-of-Life Decisions* at 9 (these devices have "great" benefits: "providing peace of mind for ourselves and our loved ones by making decisions that are in harmony with our faith and our beliefs about stewardship").

an individual's "own conception of [his or] her spiritual imperatives."[17]

The spiritual aspects of suffering differ from one terminally ill individual to another. Some view their suffering as connected with the suffering of Jesus, and thus as a cross that must be borne until God chooses to lift it. *See* Campbell, 2 Kennedy Inst. of Ethics J. at 268-69. For others, however, the suffering and loss of dignity associated with terminal illness is seen *not* as bringing them closer to God, but as distancing them from God. *See* W. Farley, *Tragic Vision and Divine Compassion* 53-59 (1990) (observing that suffering "reduces the capacity of the sufferer to exercise freedom, to feel affection, to hope, to love God").[18] Moreover, as a result of diminished physical capabilities or mental acuity resulting from the illness itself or from pain medications, an individual may lose the ability to pray, to study the teachings of his or her faith, or to interact meaningfully with family, clergy, or members of the religious community. In effect, terminally ill individuals may be forced to exist without their fundamental religious liberties during their final days.

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[17] Some *amici* opposed to physician-assisted suicide have focused on the physically painful nature of terminal illness, which they contend can be treated by proper medication and hospice care. Medication, however, cannot always relieve the pain associated with many terminal illnesses. Moreover, medication can never address an individual's anguish about his or her loss of "personhood," including the loss of physical mobility, mental acuity, emotional connection to other people, and spiritual connection to God. *See* Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 22; United Church of Christ, *Making End-of-Life Decisions* at 4.

[18] *See also* Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 22 (noting that suffering "can be destructive of moral and spiritual values and the very dignity with which God has endowed us"); Campbell, 2 Kennedy Inst. of Ethics J. at 269 (suggesting that suffering "presents a threat to the integrity and identity of the self").

Hence, the decision whether to hasten a rapidly impending death will be resolved differently by different individuals, based on their own philosophical, ethical, and religious beliefs. Some will reject physician-assisted suicide as contrary to the teachings of their faith. That decision is, of course, entitled to the utmost respect. Others, however, may conclude that physician-assisted suicide is a morally appropriate choice — perhaps the most morally appropriate choice — in the circumstances according to their understanding of the teachings of their faith. *See, e.g.*, G. Larue, *Playing God, supra,* at 396 (some terminally ill persons view a voluntarily hastened death as a "profoun[d] exercise [of] their faith"); Episcopal Diocese of Newark Task Force on Assisted Suicide, *Report* 9 (1996) (suggesting that there are circumstances in which "involuntary prolonged physical existence is a less ethical alternative than a conscientiously chosen and merciful termination of earthly life").

That decision, too, should be respected by the government. It is a decision that implicates an individual's right under the Free Exercise Clause "to maintain theories of life and of death and of the hereafter." *United States v. Ballard,* 322 U.S. 78, 86 (1944). Just as the Free Exercise Clause protects an individual's right to pursue his or her own understanding of the mysteries of life and death, *see, e.g., id.*, the Due Process Clause should protect an individual's right to make an informed decision whether to continue life in the face of a terminal illness. *See Casey,* 505 U.S. at 851 ("the right to define one's own concept" of, *inter alia*, "the mystery of human life" is "[a]t the heart of liberty"). Like other expressions of belief that emanate from "the kingdom of the individual man and his God," an individual's choice of physician-assisted suicide "should be kept . . . private," not "confounded with what legislatures legitimately may take over into the public domain." *Everson v. Board of Education,* 330 U.S. 1, 57-58 (1947) (Rutledge, J., dissenting).

For these reasons, the Washington and New York statutes are irreconcilable with the motivating spirit of the First and Fourteenth Amendments. Those terminally ill persons whose religions recognize that physician-assisted suicide is an

appropriate ethical and moral choice, or that the determination is best left to the individual's own conscience, are prevented from making this most personal decision in accordance with their "own conception of [their] spiritual imperatives." *Casey*, 505 U.S. at 852.

B. The Interests Reflected In The Establishment Clause Confirm That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty

The "purposes" and "reasons" underlying the Establishment Clause provide further support for recognizing physician-assisted suicide as a core constitutionally protected liberty under the Due Process Clause. *See Poe*, 367 U.S. at 542 (Harlan, J., dissenting). State bans on physician-assisted suicide are so akin to a government endorsement of religious doctrine as to raise serious Establishment Clause concerns.

At the core of the Establishment Clause is a prohibition on governmental favoritism of a particular religion or of religion generally: "A proper respect for both the Free Exercise and the Establishment Clauses compels the State to . . . favo[r] neither one religion over others nor religious adherents collectively over nonadherents." *Board of Education of Kiryas Joel Village School Dist. v. Grumet*, 114 S. Ct. 2481, 2487 (1994) (citation and internal quotation omitted). This Court has thus carefully scrutinized government action that appears to endorse or reject a religious position, or to compel or coerce support for a religious belief or practice. *See, e.g., Lee v. Weisman*, 505 U.S. 577, 587-88 (1992); *Grand Rapids School Dist. v. Ball*, 473 U.S. 373, 389-90 (1985); *Lynch v. Donnelly*, 465 U.S. 668, 690-94 (1984) (O'Connor, J., concurring). In adopting a view of physician-assisted suicide that is sponsored by, *e.g.*, the Roman Catholic Church, but not accepted by, *e.g.*, the Unitarian Universalist Association, the Washington and New York assisted-suicide bans, in essence, endorse one religious viewpoint to the exclusion of all others. Such endorsement of religious views runs contrary to the "purposes" and "reasons" behind the Establishment Clause.

The statutorily imposed requirement that the terminally ill endure their suffering, rather than terminate it by physician-assisted suicide, conveys an endorsement of the belief, not shared by all religions, that suffering is religiously significant and appropriate. More specifically, the states' efforts to draw a line between "passive" methods of hastening death (which they concede are permissible) and "active" methods (which they argue are impermissible) does nothing less than legalize one religious view and criminalize others.[19] This effectively "prescribe[s] what shall be orthodox" with respect to voluntarily hastened death, and compels the terminally ill "to confess by . . . [the] act [of their continued existence in the face of suffering] their faith therein." *West Virginia Board of Education v. Barnette*, 319 U.S. 624, 642 (1943).

To be sure, this Court has held that statutes do not violate the Establishment Clause simply because they reflect "traditionalist" values. *See Harris v. McRae*, 448 U.S. 297, 319-20 (1980). But bans against assisted suicide are not merely reflections of a "traditionalist" view. To the contrary, laws against suicide stem from the incorporation into the English common law of the canon

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[19] *See, e.g.*, New York Br. 16-18 (attempting to justify New York's ban on physician-assisted suicide by reference to the "difference between action and inaction"); United States Catholic Conference *et al.* Br. 18 n.11 (suggesting that *actively* hastening one's own death is a sin); Union of Orthodox Jewish Congregations & Rabbinical Council Br. 7-8 (interpreting Jewish law as forbidding *active* methods of hastening death but allowing passive methods in some circumstances); Evangelical Lutheran Church Br. 3 (arguing that the distinction between active and passive methods of hastening death is firmly grounded "within the limits of Christian charity"); Brief for the United States and New York Catholic Conferences as *amici curiae* 25 n.63, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (No. 95-7028) (arguing that the "ethical difference between action and inaction "has long been acknowledged by the Christian moral tradition" and that the "refusal of a technique which is already in use . . . is not the equivalent of [the sin of] suicide"). *See generally* Campbell, 2 Kennedy Inst. of Ethics J. at 258-63 (table of "Religious Views on the Right to Die").

law of the Roman Catholic Church. This should cause these bans on assisted suicide to raise Establishment Clause concerns. In this regard, a summary of the origins of suicide laws may be useful to the Court.

"There is nothing in the Old Testament which can clearly be understood as offering explicit judgment on the ancient Judaic view of suicide"; nor is there any "offering in the New Testament to suggest a condemnation of suicide." Neely, *The Right to Self-Directed Death: Reconsidering an Ancient Proscription,* 36 Cath. Law. 111, 121 (1995). In fact, "[i]n the Bible, five people are reported to have ended their own lives (I Samuel 31, II Samuel 17, I Kings 16 and Matthew 27), and the fact of their action is simply reported with no moral judgement implied; at no point is condemnation expressed for their having done so." G. Larue, *Playing God, supra* at 420-22 (quoting Rev. Sallierae Henderson).

Among early Christians, in fact, suicide was not particularly unusual. Because "the supreme duty in this life was to avoid the sin which would result in eternal damnation," the early Christians considered it permissible to commit suicide rather than risk condemnation. Neely, 36 Cath. Law. at 121. Indeed, given that martyrdom at the hands of infidels was an especially prized end, "fanatical Christians" — in particular, a sect known as the Circumcelliones — would invite their own death by "taunt[ing] their Roman persecutors into acts of violence." *Id.* at 122; *see also* G. Williams, *The Sanctity of Life and the Criminal Law* 254-55 (1957); *Compassion in Dying v. Washington,* 79 F.3d 790, 808 (9th Cir.) (*en banc*), *cert. granted,* 117 S. Ct. 37 (1996).

Augustine, who opposed the Circumcelliones' excesses in the name of religion, became "the chief architect" of the Roman Catholic view that suicide is encompassed by the Commandment against killing. G. Williams, *supra* at 255. "St. Augustine argued that committing suicide was a 'detestable and damnable wickedness' and was able to help turn the tide of public opinion" against suicide. *Compassion in Dying,* 79 F.3d at 808 (citing Marzen *et al., Suicide: A Constitutional Right?,* 24 Duq. L. Rev. 1, 27 (1985)). Augustine's views on suicide were eventually

incorporated into the canon law of the Catholic Church. *See* N. St. John-Stevas, *Life, Death and the Law* 233, 249 (1961) (citing 5 A. Neander, *General History of the Christian Religion and Church* 141 (Joseph Torrey trans. 1865)). In the year 673, the Council of Hereford adopted the Roman Catholic canon law, including its prohibition against suicide, into England. *See* G. Williams, *supra* at 257. King Edgar formalized this prohibition in the year 967. *See* Neely, 36 Cath. Law. at 128.

As a result, the prohibition against suicide became part of the common law of England as it emerged around the Twelfth Century. *Id.; see also Compassion in Dying,* 79 F.3d at 845 (Beezer, J., dissenting) ("Between the decline of the Roman Empire and the rise of the Common Law, ecclesiastical law was a dominant force in the English legal order."). One of the first English law treatises, written most likely between 1220 and 1260, explained that suicide was criminalized because of the Augustinian rationale: "In the same way, in which a person may commit a felony by killing another, so he may commit a felony by killing himself, which felony indeed is said to be committed against himself." 2 H. de Bracton, *De Legibus et Consuetudinibus Angliae* 505 (Sir Travers Twiss ed. 1879). Similarly, the Court of King's Bench, writing in 1562, explained the rationale for the legal prohibition on suicide. Central to the court's analysis was the view that suicide was an "offence . . . against God" as well as "against nature" and "against the King." The Court explained that suicide was "against God" because "it is a breach of His commandment, *thou shalt not kill*; and to kill himself, by which act he kills in presumption his own soul, is a greater offence than to kill another." *Hales v. Petit,* 75 Eng. Rep. 387, 400 (1562).[20]

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[20] These three reasons were exactly the same ones articulated by St. Thomas Aquinas in his theological treatise, *Summa Theologica:* "[I]t is altogether unlawful to kill oneself for three reasons . . . [first,] suicide is contrary to the inclination of nature . . . [second,] every man is part of the community . . . by killing himself he injures the community . . . [third,] because life is God's gift to man . . . whoever takes his own

Later English legal scholars echoed the same ecclesiastical underpinnings for the laws against suicide. Sir Matthew Hale explained that the prohibition upon suicide was grounded in principal part upon religious objections: "No man hath the absolute interest of himself but: 1. God almighty hath an interest and propriety in him, and therefore self-murder is a sin against God." I M. Hale, *Historia Placitorum Coronae* *411-12 (1736). Blackstone, too, explicitly recognized that this aspect of the common law was bottomed on "religiou[s]" reasons: "[T]he law of England wisely *and religiously* considers, that no man hath a power to destroy life, but by commission from God." 4 W. Blackstone, *Commentaries* ch. 14, *189 (1765) (emphasis added). Blackstone thus called suicide a "spiritual" "offence," in that the person committing suicide was guilty of "invading the prerogative of the Almighty, and rushing into [H]is immediate presence uncalled for." *Id.*

This reasoning, although an accurate reflection of the long-standing bases for the common law's prohibitions against suicide, is contrary to our American constitutional tradition. In light of our long tradition of religious liberty, arguments that suicide is an "offence . . . against God," which "invade[s] the prerogative of the Almighty," would never be a proper basis for law in this country. Indeed, this Court's Establishment Clause jurisprudence prohibits enactments that have such a religious "purpose." *See, e.g., Epperson v. Arkansas,* 393 U.S. 97, 103 (1968); *Lemon v. Kurtzman,* 403 U.S. at 612-13; *Wallace v. Jaffree,* 472 U.S. 38, 56 (1985); *Edwards v. Aguilard,* 482 U.S. 578, 592-93 (1987).

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Under this Court's prevailing substantive due process analysis — the one articulated by the second Justice Harlan — physician-

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life, sins against God." St. Thomas Aquinas, *Summa Theologica* II-II, q. 64, art. 5 (Fathers of the English Dominican Province eds., vol. 2, pp. 1465 *et seq.*, 1947). *See also Compassion in Dying v. Washington,* 79 F.3d at 845-46 (Beezer, J., dissenting); Marzen *et al., Suicide: A Constitutional Right,* 24 Duq. L. Rev. 1, 29 (1985).

assisted suicide is a core constitutional liberty, which derives both from the specific guarantees (in particular, the religious liberty clauses of the First Amendment) and the generalized aspects of "liberty" protected by the Due Process Clause. A terminally ill individual's decision to hasten death is inextricably intertwined with notions of personhood, identity, and theology; *amici* can imagine few, if any, personal decisions more appropriate to be called a protected "liberty" under the Due Process Clause.

II. THE ASSERTED INTERESTS OF WASHINGTON AND NEW YORK CANNOT JUSTIFY THE TOTAL PROHIBITION UPON THE EXERCISE OF A CORE CONSTITUTIONALLY PROTECTED LIBERTY

As Justice Harlan suggested in *Poe* and as this Court agreed in *Casey*, "certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgement." *Poe,* 367 U.S. at 543 (Harlan, J., dissenting); *Casey*, 505 U.S. at 848-49. In the event that the Court concludes, as *amici* urge in Section I above, that physician-assisted suicide occupies a preferred place on the "rational continuum" of liberty, a "particularly careful scrutiny," *i.e.*, "strict scrutiny," should apply to the Washington and New York bans on assisted suicide. *Casey,* 505 U.S. at 848, 850-51; *Poe,* 367 U.S. at 543 (Harlan, J., dissenting). Strict scrutiny, of course, requires that a statute be the least restrictive means necessary to achieve a compelling governmental interest. Neither statute can withstand this analysis.

First, like the contraception statute at issue in *Poe,* but unlike the abortion statute at issue in *Casey,* these statutes operate as total bans on the asserted liberty interest. Thus, there is no argument available to the states that any lesser standard of scrutiny should apply. *See generally* Dorf, *Incidental Burdens on Fundamental Rights,* 109 Harv. L. Rev. 1176, 1219-32 (1996). As this Court has recognized in *Casey* and in so many other cases, statutes with "incidental effect[s]" on fundamental rights generally pass muster; "undue burden[s]" on fundamental liberty rights are always impermissible under the Due Process Clause. *Casey,* 505 U.S. at 874. The criminalization of assisted suicide

— which constitutes a total ban on that liberty — certainly cannot be categorized as having an "incidental effect" on the liberty right. *See, e.g., Loving v. Virginia*, 388 U.S. 1, 12 (1967) (statute making interracial marriage a felony).

Second, the interests that Washington and New York have proffered in support of their bans on assisted suicide simply do not withstand the "particularly careful scrutiny" mandated by *Casey* and by Justice Harlan's opinion in *Poe*. While the section of Washington's brief purporting to articulate that state's interests in banning assisted suicide (Washington Br. 33-38) is not a model of clarity, the state appears to be asserting two interests: (1) an unqualified interest in the preservation of human life, and (2) "'preventing deaths that occur as a result of errors in medical or legal judgment.'" Washington Br. 33, 34. New York appears to offer essentially the same two interests as justifications for its statute. New York Br. 19-32.

The states' first asserted interest — the preservation of life — is easily dealt with. This Court in *Casey* held that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." *Casey*, 505 U.S. at 857 (citing *Cruzan*, 497 U.S. at 278). The State's interest in preserving life in this case is appropriately seen as less weighty than the interest asserted in *Casey*, where the state's interest (which was "in the protection of *potential* life," 505 U.S. at 871 (emphasis added)) aimed to protect a potential life that was in no position to protect itself. Here, the state laws under consideration purport to protect the lives of competent adults, who are fully capable of protecting their own lives (until the terminal illness runs its course) but who have chosen, for religious and personal reasons, not to do so.[21]

[21] Moreover, it is questionable whether the states' asserted interest in preserving the life of a terminally ill person who prefers to die can properly be deemed compelling, given that the states have not sought to enforce such an interest with respect to the refusal or termination of medical treatment. *See Church of the Lukumi Babalu Aye, Inc. v. City of Hialeah*, 508 U.S. 520, 547 (1993) ("'a law cannot be regarded as protecting an interest 'of the highest order' . . . when it leaves appreciable damage to that supposedly vital interest unprohibited'") (citations omitted); *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296, 298 (1990) (Scalia, J., concurring) (arguing that the scope of the state's interest in protecting life cannot vary with the means chosen to hasten death).

The second interest — preventing error and abuse in decisions regarding death — fares no better. Even assuming that the asserted interest in preventing erroneous or abusive deaths constitutes a "compelling" state interest, neither state has satisfied its burden of establishing that a total ban on physician-assisted suicide is the least restrictive means for achieving that interest. If anything, the risk of error and abuse in physician-assisted suicide is *lower* than it is in other end-of-life decisions that the states *do not* prohibit. With physician-assisted suicide, a competent terminally ill individual is solely responsible for administering the life-ending prescription, and the individual may change his or her mind. The decision is thus voluntary and personal.

By contrast, the discontinuation of treatment according to an advanced directive or to the decision of an appointed surrogate, *cf. Cruzan*, 497 U.S. at 283, carries substantially greater risks of error and abuse, principally because the decision to discontinue treatment, and the discontinuation itself, are not simultaneous events. Yet, both Washington and New York allow this latter means of ending life, with appropriate procedural safeguards — thus confirming that less restrictive means exist for furthering the states' asserted interests in preventing error and abuse. Indeed, *Cruzan* seems already to have established that less-restrictive procedural regulations, such as Missouri's "clear and convincing" standard of proof for the withdrawal of life-sustaining treatment, can satisfy a state's interests, however compelling, in assuring

that a patient is allowed to make "an informed and voluntary choice." *Cruzan*, 497 U.S. at 280.[22]

In sum, the absolute bans on this fundamental liberty are unconstitutionally burdensome; they are far more restrictive than necessary to serve either of the asserted state interests.

CONCLUSION

The judgment of the Court of Appeals for the Second Circuit in No. 95-1858, and the judgment of the Court of Appeals for the Ninth Circuit in No. 96-110, should be affirmed.

Respectfully submitted,

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[22] It has also been recognized that any risk that the terminally ill individual is coerced into choosing to hasten death is minimized where the choice is made only after extensive consultation with family, friends, health care professionals, and clergy. *See* R. Westley, *When It's Right to Die: Conflicting Voices, Difficult Choices* 168-69 (1995); *see also* G. Larue, *Playing God*, *supra* at 25-26 (noting the variety of unofficial "countercontrols" that will assure that the decision is informed and voluntary). Moreover, in order to bolster these informal checks on coercion, the states may regulate physician-assisted suicide to assure competency and voluntariness. *Cf. Cruzan*, 497 U.S. at 280.

APPENDIX

APPENDIX

STATEMENTS OF INTEREST OF *AMICI CURIAE*

AMERICANS FOR RELIGIOUS LIBERTY is a nonprofit public interest educational organization dedicated to defending religious liberty, freedom of conscience, and the constitutional principle of separation of church and state. Americans for Religious Liberty has participated as an *amicus* in other cases in this Court that have implicated these concerns. Americans for Religious Liberty believes that bans on physician-assisted suicide conflict with fundamental First Amendment guarantees.

THE AMERICAN HUMANIST ASSOCIATION, founded in 1941, has members and local affiliates throughout the United States. The Association has adopted a formal statement on physician-assisted suicide that recognizes an individual's right to exercise control over the manner and time of dying subject to adequate safeguards assuring that such actions are wholly voluntary and clinically appropriate. Consonant with the principles of autonomy, dignity, and freedom of conscience underlying the First and Fourteenth Amendments, the Association believes that the right to hasten death with the aid of a physician should be protected by this Court.

THE BOARD OF DIRECTORS OF THE SOCIETY FOR HUMANISTIC JUDAISM oversees an organization that reflects the beliefs of approximately one-fifth of the world's Jewish population, and is dedicated to the promotion of Jewish and humanistic ideals, including human dignity, integrity, tolerance, and equal treatment. In view of its respect for the autonomy and dignity of the individual and its compassion for those who are suffering, the Board of Directors believes that a terminally ill person's decision to end his or her suffering should be honored. The Board of Directors thus affirms that competent adults should have the right to make responsible decisions regarding the most profound and private aspects of their own lives — including the choice to hasten death in the face of terminal illness — free from government interference and subject to regulation only to the extent necessary to provide appropriate safeguards.

THE CATHAR CHURCH, which has approximately 25,000 members, is Evangelical in basic doctrine and is in many respects similar to the Amish, Brethren, and Mennonite families of churches. Throughout its long history, the Cathar Church has taught that people desiring to end their suffering by hastening death are entitled to dignity, sympathy, and support, and that their decision is a matter of individual conscience to be judged only by God. The Cathar Church believes that medical practitioners should be able to provide aid in dying, subject to guidelines to guard against abuse, and thus supports a constitutionally protected right to physician-assisted suicide.

THE CONGRESS OF SECULAR JEWISH ORGANIZATIONS is composed of several independent organizations that seek to forge a Jewish identity that is grounded in contemporary life and is committed to the social values of justice, peace, and community responsibility. Consistent with this purpose, the Congress has taken the position that a competent, terminally ill adult who is gripped by unbearable suffering should have the right to assistance in dying, subject to adequate safeguards that ensure that the decision is informed, rational, and voluntary.

THE EPISCOPAL DIOCESE OF NEWARK is one of the largest Episcopal dioceses in the United States, representing 123 congregations and more than 40,000 Episcopalians. The Diocese believes that choices about death are matters of individual conscience informed by scripture, tradition, and reason. Accordingly, the Diocese has resolved that suicide may be a morally appropriate choice for Christians who are suffering from a terminal illness characterized by persistent and irremediable suffering and who voluntarily make an informed decision to hasten death. The Diocese has further resolved that assisting another in accomplishing voluntary death under these circumstances may be an equally moral choice.

THE UNITARIAN UNIVERSALIST ASSOCIATION is a religious association of more than 1,000 congregations in the United States and Canada. In 1988, the Association adopted a resolution affirming the right to self-determination in dying and supporting

the elimination of civil and criminal penalties against those who, under proper safeguards, assist terminally ill patients in selecting the time and manner of their own deaths.

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THE REVEREND GLEN A. HOLMAN of Sacramento, California (Christian Church (Disciples of Christ)).

DOCTOR GERALD LARUE, Emeritus Professor of Religion, Adjunct Professor of Gerontology, University of Southern California.

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Nos. 95-1858 and 96-110

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.; THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SECOND CIRCUIT AND FOR THE NINTH CIRCUIT

BRIEF FOR THE NATIONAL WOMEN'S HEALTH NETWORK AND NORTHWEST WOMEN'S LAW CENTER AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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CONSENT OF THE PARTIES

All Petitioners and Respondents in both *State of Washington, et al. v. Glucksberg, et. al.*, No. 96-110, and *Vacco, et al. v. Quill, et. al.*, No. 95-1858, have consented to the filing of this brief. Their letters of consent are being filed herewith.

INTEREST OF *AMICI CURIAE*

Amicus National Women's Health Network (the "Network") is the only national public-interest membership organization devoted solely to women and health. Founded in 1974, the Network has influenced national policy as a women's voice dedicated to humane, responsive health care. *Amicus* Northwest Women's Law Center ("NWLC") is a non-profit public interest organization dedicated to advancing the legal rights of women through litigation, legislative advocacy, education and an information and referral telephone service. Since its founding in 1978, the NWLC has been dedicated to protecting the fundamental rights to liberty, privacy, autonomy and bodily integrity. The NWLC has participated in litigation opposing a variety of state restrictions on individual liberty in the context of abortion and reproductive freedom.

Amici, women's rights organizations and advocates, explain why these cases raise constitutional issues of special importance to women. Although the criminal statutes challenged here do not use gender-based classifications, and the fundamental liberty interest at stake here is of vital concern to all people, women's perspectives on this Court's fundamental liberty jurisprudence are distinctive because the law and the Constitution have treated men and women as different. Much of that jurisprudence has been developed in the context of state legislative restrictions on contraception and abortion, matters of special interest to women. This brief discusses how the treatment of women under our Constitution and laws supports the claims advanced by the Respondents in these cases.

SUMMARY OF ARGUMENT

These cases require the Court to resolve whether terminally ill people have a constitutionally protected interest in controlling the circumstances of their death and whether that interest is violated by an absolute and uncompromising ban on physician assistance. *Amici* urge the Court to affirm the decisions of the Ninth Circuit, *en banc*, and the Second Circuit holding that terminally ill individuals have a constitutionally protected liberty interest in controlling the circumstances of their deaths. That liberty interest precludes states from enacting blanket criminal prohibitions on doctors who facilitate the choices of competent, terminally ill patients who seek to hasten death. The experience of women under the Constitution and laws supports this Court's protection of such fundamental and basic personal rights of liberty and choice.

This Court's precedents recognize a principled and cohesive concept of liberty that guards against unwarranted state interference with highly intimate, personal choices—those that are central to dignity and autonomy—including choices relating to marriage, childbirth, family relations and death. Although the constitutional protection of fundamental liberty is vital to all people, many of the situations in which this Court has protected fundamental liberty against state inference are of particular importance to women. Under this Court's ordered and principled conception of fundamental liberty, the choice of a terminally ill person about the circumstances of his or her death must be protected against blanket state prohibition on physician assistance.

In order to reverse the decisions below, Petitioners the State of Washington and the State of New York (the "States") and many of the *amici* who support their position suggest that the Constitution protects only those rights specifically recognized when the Constitution or the Fourteenth Amendment was adopted. This wooden, historically frozen

concept of constitutionally protected liberty poses a particular threat to women (among other historically oppressed populations) because, both in 1789 and in 1868, our Constitution and laws pervasively and explicitly denied women personal, civil and political rights. Although history and tradition can serve as useful guides in the interpretative process, the Constitution's guarantee of liberty ultimately must be interpreted in a principled manner that acknowledges a cohesive and evolutionary concept of liberty and that is sensitive to the social inequalities imbedded in our history and traditions.

The States contend that even if the laws at issue here implicate a fundamental liberty interest, they nonetheless pass constitutional muster. This Court has long held that a state law that burdens the exercise of fundamental liberties must be carefully tailored to serve important state interests. The States offer two core justifications for their absolute criminal ban on physician assisted suicide: first, the desire to protect vulnerable people from coercion by banning even the authentic and informed choices of terminally ill people; and second, the desire to promote respect for life, regardless of the circumstances or conscientious choices of the person who is living it. Both of these purposes asserted by the States (or closely analogous purposes) have historically been utilized in ways that have been particularly damaging to women.

The States' blanket ban on physician assisted suicide does not protect individual choice from coercion, but instead prohibits Respondents from freely choosing to exercise a fundamental liberty. A state may act to prevent coercion, to assure authentic choice, to encourage the medical profession to do a better job of treating pain and depression, and to address a wide range of legitimate state concerns about the welfare of its people. But it must do so by enacting properly tailored laws that safeguard the rights of all individuals to exercise their fundamental liberties, which include the right

of a terminally ill person to choose freely (with the advice of a doctor and in accordance with his or her conscience) whether to hasten death. Women's experience under the laws and Constitution—and particularly the experience of women prior to this Court's recognition that the Constitution protects individual choice over procreation—illustrates that people are injured, the quality of their lives diminished and their humanity denied when the law prohibits free and authentic choice about important life decisions.

The States' assertion of an absolute and overriding interest in protecting life, irrespective of the circumstances, has been squarely rejected by this Court. That interest has been most often asserted to defend laws that deny women their fundamental liberty to choose abortion. Women's experience in seeking legal and constitutional protection for reproductive choice counsels an imperative need for careful scrutiny of state efforts to use the criminal law to mandate the perpetuation of life over all competing interests, including such valid and compelling interests as the desires, needs and indeed fundamental rights of the person who must live that life.

Finally, in the courts below, the States urged a rule of constitutional interpretation that would dictate that a law that is challenged as violating a fundamental constitutional right may not be held unconstitutional unless it is invalid in every conceivable situation to which it might apply. This rule has no application to these cases, because Respondents challenge the laws at issue here as applied only to them and similarly situated people. Indeed, the States do not argue that this is an appropriate case for this Court to apply the rule they urged below. Moreover, even if applicable to these cases, the rule is inconsistent with the principles and practices of the last two centuries and would threaten all constitutionally protected liberties, including those that are particularly important to women.

ARGUMENT

I. TRADITIONAL CONCEPTS OF CONSTITUTIONAL LIBERTY PROTECT THE CHOICES OF COMPETENT, TERMINALLY ILL PEOPLE.

The liberty interest asserted by the Respondents in these cases encompasses several elements. Competent people who are confronted with imminent death because of terminal illness no longer enjoy many of the most significant aspects of life and choice. For Respondents then, the most meaningful liberty left available to them is the ability to control the circumstances of death. Justice Stevens eloquently described this interest in *Cruzan v. Missouri Dep't of Health*:

> "Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental' . . . .
>
> The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience. We may also, however, justly assume that death is not life's simple opposite, or its necessary terminus, but rather its completion. Our ethical tradition has long regarded an appreciation of mortality as essential to understanding life's significance. It may, in fact, be impossible to live for anything without being prepared to die for something."

497 U.S. 261, 343 (1990) (Stevens, J., dissenting) (citations omitted).[1] As Justice Stevens recognized, the power of the terminally-ill to choose the circumstances and timing of death is fundamental, however that choice is exercised.

Decisions regarding the circumstances and timing of one's death also implicate rights of intimate association. No state currently prohibits suicide, but many terminally ill patients who would choose to die in a private, dignified, non-violent and effective manner that requires physician assistance are prohibited from doing so by the statutes at issue here. A criminal ban on physician assistance to the terminally-ill forces those individuals to act alone and prevents them from seeking the support and comfort of their physicians and their loved ones. When suicide is allowed, but help in dying is prohibited, the terminally-ill person is left to die alone and often with prolonged pain.[2] Thus, the state denies the

---

[1] Although Justice Stevens articulated this principle in a dissent, the Court did not disagree with his formulation of the liberty interest at state. Rather, the Court split over whether a state could impose a heightened evidentiary standard before a terminally ill patient could exercise that liberty interest by terminating a life support system. *See infra* note 24.

[2] Respondent Dr. Timothy Quill offers this reflection on the death of Diane, the long-term patient to whom he had provided barbiturates:

> "I did not want her to have to face this final moment alone. Had she asked me to be with her, and had I complied, the legal risk of my participation would have increased substantially. She died alone as a final altruistic act to protect both her family and me from potential prosecution. She researched the law in the state of New York and rightly discovered that the legal risk of the assisters increases dramatically if they are present at the time of death."

Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039, 1040 (1993).

Different terminally ill people make different choices. Andrew Solomon describes his mother, who went through months of aggressive treatment for cancer. She said:

> "As long as there is even a remote chance of my getting well, I'll go on with treatments. When they say that they are keeping me alive but without any chance of recovery, then I'll stop."

Andrew Solomon, *A Death of One's Own*, The New Yorker, May 22, 1995, at 58. At the end,

> "[she] considered doing the whole thing on her own but had thought that the shock would be worse than the memories of having been with her for the experience. As for us, we wanted to be there. My mother's life was in other people, and we all hated the idea of her dying alone."

Id. at 64.

terminally-ill profoundly important rights of intimate association.

The interest that Respondents assert is well rooted in this Court's precedents. Throughout our history, this Court has interpreted the Constitution to protect basic individual rights of personal liberty, choice and intimate association.[3] In *Griswold v. Connecticut*, the Court held that the liberty protected by the Constitution encompasses married people's right to use contraceptives and look to their physicians to help obtain them. 381 U.S. 479 (1965). This Court has recognized that "[t]he full scope of the liberty guaranteed by the Due Process Clause . . . is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints".[4] *Griswold* offers a principled and reasoned approach to defining liberty, an approach which is in the mainstream of this Court's precedents.[5] A dying person's interest in controlling the

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[3] *See, e.g., Meyer v. Nebraska*, 262 U.S. 390 (1923) (striking a law that prohibited parents from teaching their children in a language other than English); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (striking a law that required parents to send their children to public school).

[4] *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds of an earlier challenge to the Connecticut ban on birth control).

[5] *See, e.g., Roe v. Wade*, 410 U.S. 113 (1973); *Cruzan v. Missouri Dep't. of Health*, 497 U.S. 261 (1990); *Planned Parenthood of*

circumstances and timing of his or her own death falls squarely within the "rational continuum" of liberty recognized in *Griswold*.[6]

Women have a special interest in preserving and developing the protection of liberty recognized in *Griswold*. Despite the fact that a law denying married people access to contraception impacts married men as well as married women, as a practical matter, married peoples' inability to control fertility hurts women more than it does men.[7] Many of the other contexts in which the Court has found that state laws violate individual liberty also present issues of particular importance to women.[8] This Court should not retreat from the principled approach to liberty recognized in *Griswold*, because the freedom and autonomy of women and other historically oppressed groups depend so heavily on the fundamental liberties that this Court has historically protected.

Southeastern Pa. v. Casey, 505 U.S. 833 (1992).

[6] *See Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water"); *Compassion in Dying v. Washington*, 79 F.3d 790, 803-806 (9th Cir. 1996) (*en banc*).

[7] Women are not the only group specially impacted by the liberty interest recognized in *Griswold*. Prior to *Griswold*, in Connecticut, educated married couples who had money obtained and used contraceptives, and the burden of the criminal prohibition fell on the uneducated and the poor. *See* David J. Garrow, *Liberty and Sexuality: The Right to Privacy and the Making of* Roe v. Wade 197 (1994).

[8] *See, e.g., Carey v. Population Services International*, 431 U.S. 678 (1977) (recognizing minor's right to purchase non-prescription contraceptives without parental consent); *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (recognizing right of family members to live together); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (recognizing unmarried people's right to obtain contraceptives).

The Solicitor General seeks to trivialize Respondents' claims that the criminal bans challenged here violate fundamental rights to choice, autonomy, dignity, privacy and intimate association by narrowing the claimed interest to a desire to "avoiding severe pain or suffering".[9] For Respondents and the physicians who serve them, the power to choose the circumstances and timing of their death involves far more than simply avoiding pain or suffering. It involves an act of self-assertion and self-control over the only thing they can control. It involves the ability to end their lives in a dignified, painless manner in the presence of their physicians and loved ones. In short, Respondents' claim to choice implicates "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy". *Casey*, 505 U.S. at 851.

II. AN HISTORICALLY FROZEN CONCEPT OF LIBERTY IS CONTRARY TO THIS COURT'S PRECEDENTS AND POSES A SPECIAL THREAT TO WOMEN.

In recent years, an alternative approach to the definition of constitutionally protected liberty has been offered. That approach resolves claims to constitutional liberty by reference "to the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified".[10] The States, and the lower court judges who

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[9] Brief for the United States as *Amicus Curiae*, in No. 96-110 ("United States Br.") at 16.

[10] *Michael H. v. Gerald D.*, 491 U.S. 110, 128 n.6 (1989) (Scalia, J.) (citing in part *Bowers v. Hardwick*, 478 U.S. 186 (1986)) (denying a biological father the right to visit with his daughter, with whom he had an established relationship, because the mother subsequently married another man). Chief Justice Rehnquist joined this opinion. Justice O'Connor concurred "in all but footnote 6 of Justice Scalia's opinion". *Id.* at 132. Justice Kennedy joined Justice O'Connor's concurrence. Justice Stevens concurred in the judgment. Justices Brennan, Marshall, Blackmun

would deny Respondents' assertion of constitutionally protected liberty, rely primarily on this alternative jurisprudence, arguing that the Constitution protects only those liberty interests that were specifically protected in our Nation's history and tradition.[11] Such a wooden historical approach to constitutional jurisprudence is at odds with this Court's precedents and is particularly threatening to women.

This Court's precedents demonstrate an unwillingness to freeze the right to be free from arbitrary government interference within a static tradition or history. Notions of fundamental liberty and privacy have evolved continuously as our society has changed. Indeed, Justice Harlan stated over 30 years ago that the concept of liberty embodied in this Court's precedents has never "been reduced to any formula"

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and White dissented.

[11] The States and many of the *amici* who support their position read this Court's decision in *Bowers v. Hardwick*, 478 U.S. 186 (1986), as supporting an historically frozen concept of constitutionally protected liberty. *See, e.g.*, Brief for the Petitioner, in No. 96-110 ("Washington Br.") at 21-25 (arguing fundamental liberty must be "'deeply rooted in this nation's history and tradition'") (citing *Bowers*, 478 U.S. at 191-92); Brief *Amici Curiae* of The Legal Center for Defense of Life, Inc. and The Pro-Life Legal Defense Fund at 3-4. In rejecting Respondents' liberty claims, the Second Circuit considered itself bound by the States' reading of *Bowers*, and observed that "[its] position in the judicial hierarchy constrains [it] to be even more reluctant than the Court to undertake an expansive approach in this unchartered area". *Quill v. Vacco*, 80 F.3d 716, 725 (2d Cir. 1996). Similarly, the judges who dissented from the Ninth Circuit's *en banc* decision in favor of Respondents relied heavily on their perception of this Court's "unwillingness" to find new fundamental rights. *Compassion in Dying v. Washington*, 79 F.3d 790, 848 (9th Cir. 1996) (*en banc*) (Beezer, J., dissenting); *see also Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995) (Noonan, J.) (refusing to "invent" a constitutional right that did not previously exist), *rev'd* 79 F.3d 790 (9th Cir. 1996) (*en banc*).

nor "determined by reference to any code".[12] The Court has continued to affirm that the constitutional protection of fundamental liberties cannot be limited by a static reading of history and tradition: "Neither the Bill of Rights nor the specific practices of the States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects". *Casey*, 505 U.S. at 848.

The formalistic definition of liberty urged by the States would have a particularly detrimental impact on women. It would freeze for all time the social inequalities suffered currently by women and eliminate all chances for judicial or constitutional facilitation of the achievement of gender equality. It would allow a state to enact legislation that reinforced "its own vision of the woman's role" anywhere that vision can be found to be rooted in "our history and our culture". *Casey*, 505 U.S. at 852. As Justice Ginsburg recently reminded us, "'our Nation has had a long and unfortunate history of sex discrimination'". *United States v. Virginia*, 116 S. Ct. 2264, 2274-75 (1996) (citation omitted). At the time of the adoption of the Fourteenth Amendment, married women were deemed not to exist in the eyes of the law: they were not allowed to hold property, to contract, or to vote. Moreover, until the latter half of this century, the law explicitly sought to "perpetuate the legal, social, and economic inferiority of women". *Id* at 2276. The Constitution's basic guarantee of "liberty" must be interpreted

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[12] *Poe*, 367 U.S. at 542 (Harlan, J., dissenting); *see also Rochin v. California*, 342 U.S. 165, 169 (1952) (Frankfurter, J.) ("In dealing not with the machinery of government but with human rights, the absence of formal exactitude or want of fixity of meaning, is not an unusual or even regrettable attribute of constitutional provisions").

to prevent and redress such historical inequities, not to *reinforce* them.[13]

This Court has refused to embrace an historical definition of liberty that traps us in a stagnant society and abandons marginalized groups and unconventional life choices to oppressive government regulation.[14] *Griswold* raised such issues. Although the general "public opinion . . . of a bygone day" condemned the use of contraceptives, *Poe*, 367 U.S. at 546-57 n.12 (Frankfurter, J.), this Court correctly held that the Constitution protects a married person's right to obtain contraceptives. Likewise, this Court recognized in *Casey* that "interracial marriage was illegal in most States in the 19th century, but the Court was no doubt correct in finding it to be an aspect of liberty protected against state interference by the substantive component of the Due Process clause in *Loving v. Virginia*, [388 U.S. 1 (1967)]". 505 U.S. at 848. Indeed, in *Casey*, this Court expressly refused to interpret the Constitution by reference to an historical tradition that placed women at the "center of home and family" because that tradition is "no longer consistent with our understanding of the family, the individual, or the Constitution". 505 U.S. at 897.[15]

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[13] *See, e.g., Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) (holding mother's marriage to an African-American does not justify changing custody to father; "[p]rivate biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect"); *Orr v. Orr*, 440 U.S. 268 (1971) (state may not require that husbands, but not wives, pay alimony).

[14] *See National Mut. Ins. Co. v. Tidewater Transfer Co.*, 337 U.S. 582, 646 (1949) (Frankfurter, J., dissenting) ("Great concepts like . . . 'liberty,' . . . were purposely left to gather meaning from experience [,] [f]or . . . only a stagnant society remains unchanged.") (citations omitted).

[15] As the Ninth Circuit held, "if historical evidence of accepted practices at the time the Fourteenth Amendment was enacted were dispositive, this Court would not only have decided *Loving* differently, but it would not have held that women have a right to an abortion". 79 F.3d at 806.

The Solicitor General implicitly recognizes that a concept of constitutionally protected liberty frozen in 1868 is inconsistent with well established principles, and that it threatens all people whose equality and liberty were historically and wrongfully denied under our Constitution and laws.[16] Nonetheless, the Solicitor General offers a frozen and artificial concept of liberty: the Solicitor General suggests that the Court should recognize the liberties that had been deemed by this Court to be protected by the Constitution up through 1992, with the Court's decision in *Casey*, but go no further. According to the Solicitor General, then, a bench mark date of 1868, when equal protection and liberty were blatantly and pervasively denied to women and others would be wrong, but adopting a random but pleasing (in that it stops short of recognizing the right to determine the time and manner of death) benchmark date of 1992 is appropriate. This formulation is as flawed and inflexible as the States' interpretation, and for the same reasons.

This Solicitor General's predecessor, Charles Fried, offered a similar argument in 1989, urging that the Court overrule *Roe*, but retain *Griswold*.[17] The Court has rejected that argument and reaffirmed that "'liberty' is not a series of isolated points . . . [Rather i]t is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which

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[16] United States Br. at 16-18.

[17] Specifically, in oral argument in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), Solicitor General Fried argued: "The government is not asking the Court to unravel the fabric of privacy rights but rather just to pull this one thread". Frank Susman, the lawyer for the women, responded that in his experience "when someone pulls a thread, the sleeve falls off." *See* Supreme Court Proceedings, Argument Before the Court, 57 U.S.L.W. 3715 (May 2, 1989).

also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment."[18] This Court should likewise reject the current Solicitor General's attempt to freeze the development of our concept of fundamental liberty in 1992.

Apparently appreciating the grave threat that the States' anemic concept of liberty poses to women, the Solicitor General suggests that concepts of gender equality will suffice to protect certain rights of particular concern to women (like abortion) that have historically been protected as an aspect of fundamental liberty under our Constitution.[19] Many scholars have advanced gender equality arguments in support of fundamental liberty interests in reproductive choice.[20] *Amici*

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[18] *Casey*, 505 U.S. at 848-49 (quoting *Poe*, 367 U.S. at 543 (Harlan, J., dissenting)) (internal quotations omitted).

[19] The Solicitor General quotes a law review article critique of physician assisted suicide that states: "'Requiring women to bear unwanted children threatens to lock them into a traditional and subordinate role, embodies assumptions about their inability to make autonomous moral choices, and burdens women as a group with obligations that have no counterpart in the burdens that the State demands from men'". United States Br. at 17 (citing Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay On Roe, Casey, And The Right To Die*, 44 Am. U.L. Rev. 803, 849 (1995)).

[20] *See, e.g.*, Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. Rev. 375 (1985); Kenneth Karst, *The Supreme Court, 1976 Term - Forward: Equal Citizenship Under the Fourteenth Amendment*, 91 Harv. L. Rev. 1, 53-59 (1977); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955 (1984); Herma Hill Kay, *Models of Equality*, 1985 U. Ill. L. Rev. 39; Katharine A. MacKinnon, *Reflections on Sex Equality under Law*, 100 Yale L. J. 1281 (1991); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan L. Rev. 261 (1992); Laurence H. Tribe, *Abortion: The Clash of Absolutes* 105 (1992).

support a concept of gender equality that encompasses concern with protection of fundamental rights of reproductive choice and will applaud judicial development of constitutional principles that recognize that reproductive choice encompasses issues of both gender equality and fundamental liberty. As the Court recognized in *Casey*, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives". 505 U.S. at 856.[21] Nonetheless, women have learned that their ability to participate fully in society depends on this Court's recognition of a principled and cohesive concept of liberty that embraces a wide range of highly intimate and personal decisions.[22] This Court should not retreat from its precedents recognizing such fundamental liberties in favor of a frozen and wooden concept of liberty merely because certain rights that are important to women may continue to be protected as a matter of gender equality.

III. WOMEN'S EXPERIENCES DEMONSTRATE THAT LIBERTY AND EQUALITY ARE THREATENED BY OVERBROAD PROTECTIONIST LEGISLATION.

The central argument offered to support imposing criminal sanctions on doctors who assist terminally ill patients to exercise their constitutional rights in the face of death is that

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[21] *See also id.* at 852 ("[a pregnant woman's] suffering is too intimate and personal for the State to insist, without more, upon its own vision of the women's role, however dominant that vision has been in the course of our history and our culture").

[22] As shown above, cases such as *Griswold*, *Eisenstadt*, and *Moore*, which are at the heart of this Court's historic commitment to the protection of a principled and cohesive concept of liberty, have been particularly important to women. Those cases recognize a liberty interest that is enjoyed by both men and women, but that, as a practical matter, is more important to women because of the inequities suffered by women. *See supra* at 7-8.

the ban is necessary to protect certain vulnerable people.[23] As the debate among the Justices in *Cruzan* underscores, the question of how best to protect authentic individual choice where the individual whose life is at stake cannot make his or her own decisions is a complex matter.[24] The present cases, however, do not present these complex issues. Respondents here are competent, terminally ill people who have made the choice to die with as much dignity as possible, with the assistance and comfort of their physicians. Respondents' decisions are clear. Although the States may act to protect informed and authentic choice, they cannot override the fundamental right of the terminally-ill to choose the circumstances of their death merely because they want to protect others who would make different choices. And the States cannot *prevent* the terminally-ill from choosing to

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[23] Washington Br. at 33-38; Brief for the Petitioners, in 95-1858 ("New York Br." at 27-32; United States Br. at 19-32.

[24] In *Cruzan*, this Court accepted the principle that a terminally ill patient has a constitutional right to discontinue life-sustaining treatment, including a forced feeding apparatus. The Court split over whether a state could demand that the guardians of a patient in a persistent vegetative state demonstrate the patient's wishes by "clear and convincing" evidence to terminate treatment. *See* 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements."); *id.* at 31[illegible] (Brennan, J., dissenting) ("Missouri may constitutionally impose only those procedural requirements that serve to enhance the accuracy of a determination of Nancy Cruzan's wishes or are at least consistent with an accurate determination. The Missouri 'safeguard' that the Court upholds today does not meet that standard."); *cf. Casey*, 505 U.S. at 872 ("[t]hough the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed").

hasten their own deaths because the States disagree with and disapprove of their decisions to choose to die.[25]

The States argue, at bottom, that Respondents' fundamental liberty can be sacrificed as a necessary cost of protecting others: "individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions . . . . The interest of the individual cannot be separated from the interests of society as a whole".[26] The notion that "the rules of civil society must be adapted to the general constitution of things, and cannot be based upon exceptional cases,"[27] has been used historically to maintain the inequality of women under the law. In *Bradwell v. Illinois*, the Court invoked the presumed interests of society as a whole and the general social good to justify denying a qualified woman the right to practice law. *Id.* There the assumption was that Myra Bradwell was different from most women *and* that her own competence was irrelevant because allowing her to practice law would undermine general social expectations about the appropriate roles of men and women. Similarly here, the States argue that the interests of society as a whole justify denying Respondents' fundamental liberty because Respondents are presumed to be atypical.

Although a flat ban prohibiting doctors from helping competent, terminally ill people to exercise control over the circumstances of their deaths is unconstitutional, states are not

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[25] *See Hodgson v. Minnesota*, 497 U.S. 417, 435 (1990) ("[T]he regulation of constitutionally protected decisions . . . must be predicated on legitimate state concerns other than disagreement with the choice the individual has made . . . . Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity.").

[26] New York Br. at 21; *see also* Washington Br. at 40.

[27] *Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130, 141-142 (1872) (Bradley, J., concurring).

powerless to regulate in this arena. Where abuse is likely, states may act to insure voluntary and informed choices that are free from coercion. By requiring doctors to treat their patients' pain and depression, and requiring that patients be provided with information about alternatives, states may safeguard against abuse without unnecessarily and impermissibly infringing on the liberty of those who choose to die. Indeed, prominent physicians, attorneys, and other professionals have offered model regulations that would achieve the States' legitimate goals of protecting against involuntary and accidental death far more effectively than the current absolute bans.[28] Oregon's Death with Dignity Act provides another model,[29] as do the standards developed by the Respondent physicians in this case.[30] Women have often suffered coercion and abuse at the hands of the medical profession in relation to pregnancy and birth control.[31] As such, women have a keen appreciation for the ways in which narrowly tailored regulation of physicians can provide protection against malfeasance and abuse. A prohibition on choice like the ones at issue here, however, will not achieve that objective.

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[28] *See, e.g.*, F. G. Miller, et al., *Regulating Physician Assisted Death*, 331 N. Eng. J. Med. 119 (1994); Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996).

[29] 1995 Or. Rev. Stat. § 127.800 et seq.

[30] *See infra* note 36.

[31] *See, In Re A.C.*, 573 A.2d 1235 (D.C. Ct. of App. 1990) (holding that cesarian section provided against the wishes of a competent woman violated her common law rights); *Buck v. Bell*, 274 U.S. 200 (1927) (approving compulsory eugenic sterilization and implicitly overruled by *Skinner v. Oklahoma*, 316 U.S. 535 (1942)); *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D. C. 1974) (discussing coerced consent to sterilization and government efforts to prevent it in the context of the Medicaid program), *vacated by* 565 F.2d 722 (D.C. Cir. 1977).

Women's experience under the Constitution and laws of the United States evidences the dangers inherent in such overbroad, "protectionist" policies. Consider the history of the regulation of abortion in this country. The 19th century laws criminalizing abortion were adopted at the urging of the medical profession, in significant part because of a desire to "protect" women from the dangers of abortions provided by unskilled practitioners.[32] Criminal bans against abortion, however, did not prevent people from seeking or performing abortions.[33] The ban served to make the procedure more costly, more humiliating, more dangerous and often deadly.[34]

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[32] *Roe v. Wade*, 410 U.S. 113, 148-49 (1973) ("When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman . . . . Antiseptic techniques . . . were often not generally accepted and employed until about the turn of the century. Abortion mortality was high."); *see also* James Mohr, *Abortion in America: The Origins and Evolution of National Policy* 21-22, 31-32, 37 (1978).

[33] Regina Stix & Dorothy Wiehl, *Abortion and Public Health*, 28 Am J. Pub. Health 622, Table I (1938) (noting that the incidence of abortion ranged from one pregnancy in seven at the turn of the century to one in three in 1936). The Kinsey Report found that in the 1950s between one in five and one in four women who had ever been married had aborted a pregnancy. Almost 90 percent of the premarital pregnancies reported in that study were ended by abortions, most of them illegal. Paul Gebbard et al., *Pregnancy, Birth, and Abortion* 93-94, 54 (1958). In the 1950s, researchers estimated that between 200,000 and one million U.S. women had illegal abortions each year. *Abortion in the United States* 178-80 (Mary S. Calderone ed., 1958).

[34] Most illegal abortions were performed "under unsafe—usually degrading—conditions". Frederick S. Jaffe, Barbara L. Lindheim & Philip R. Lee, *Abortion Politics: Private Morality and Public Policy* 22 (1981). Illegal abortionists apprehended in the 1960s following the deaths of women "included a boat-yard worker, a real-estate salesman, a hospital orderly, and an automotive mechanic. These operators often worked under unsanitary conditions and avoided anesthesia, so they could speed women who had just been aborted on their way." *Id.* In 1961, the Center for Disease Control identified 320 deaths from complications of illegal

It also spawned a two-tiered abortion system in which the quality of medical care a woman seeking to abort received depended on her class, race and state of residence. Poor and rural women obtained illegal abortions performed by people, not necessarily doctors, willing to defy the law out of sympathy or for the fee. More privileged women crossed state lines or pressed private physicians for legal abortions.[35]

A blanket ban on physician assistance in dying does not support authentic individual choice, and, indeed, is likely to undermine it. Unregulated, renegade doctors, like back-alley abortionists, may utilize a flat ban on physician assisted suicide to obtain patients whose wishes to die may not be tempered by the careful procedural controls necessary to ensure informed consent. Indeed, it is a states's criminalization of this procedure that undermines the legitimate state interest in promoting authentic patient choice. For example, it has been reported that Dr. Kevorkian hastened death for one patient for whom Respondents in this case would not have sought death or help in dying.[36] As with

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abortions. *Id.* In 1959, abortion deaths from illegal abortions accounted for one-third of all maternal deaths. Kristen Luker, *Abortion and the Politics of Motherhood* 74 (1984). In 1927 and 1928, a fifteen-state survey found that 794 women (or ten percent of all maternal deaths) had died from the complications of illegal abortions. *Id.* at 49.

35 Luker, *supra* note 34, at 57. In addition, in the 1960s, clergy formed problem pregnancy consultation services "that referred women to competent, though illegal, practitioners. These consultation services were used primarily by women of means, not the poor." Jaffe, *supra* note 34, at 22.

36 For example, Respondent Compassion in Dying

> "will not assist anyone to commit suicide who expresses any ambivalence or uncertainty. If the patient has immediate family members or other close personal friends, their approval must be obtained. . . . Compassion in Dying requires the patient to provide medical records. A consulting physician must review them to verify the patient's terminal prognosis and decision-making capability as well as to rule out inadequate pain management as the reasons for requesting assisted suicide."

Compassion in Dying v. Washington, 850 F. Supp. 1454, 1458 (D. Wash. 1994). Other Respondent physicians would adopt similar norms to assure that patients' requests for assistance in dying is voluntary, informed and uncoerced.

Dr. Kevorkian, a retired pathologist, does not appear to apply such safeguards to assure that patients are terminally ill or that their consent is authentic and informed. From a woman's point of view, the facts of *People ex rel. Oakland County Prosecuting Attorney v. Kevorkian*, 534 N.W.2d 172, 173 (Mich. Ct. App. 1995), *cert. denied sub nom. Kevorkian v. Michigan*, 117 S. Ct. 296 (1996), are especially disturbing. Janet Adkins was 54 years old. She was diagnosed as suffering from Alzheimer's disease. But, at the time Dr. Kevorkian "helped" her to die, she "was not terminally ill nor suffering from pain." *Id.* at 174. She had played tennis within days of her death. Yet, Dr. Kevorkian "made no real effort to discover whether Ms. Adkins wished to end her life, relying largely on the statements of her husband and a few limited responses from Mrs. Adkins." *Id.*

37 Although prosecutors often sought indictments against illegal abortionists, juries rarely returned convictions. Luker, *supra* note 34, at 53. Convicted abortionists were often dealt with leniently:

> "A statistical analysis of all 111 convictions for abortion in New York County between 1925 and 1950 (about four convictions per year) indicates that 44 percent of those convicted were given probation. This is all the more remarkable when it is realized that . . . in 10 percent of the cases the woman had died as a result of the abortion."

Id. at 53-54. The experience of Dr. Kevorkian has been similar to that of the back-alley abortionist. Kevorkian has admitted to being present at 44 deaths since 1990. *See* Bill Varner, *Kevorkian vs. the Prosecutor: a Last Attempt at Conviction by Thompson*, USA Today, Nov. 1, 1996, at 3A. He has been charged with and tried for crimes stemming from his actions three times and each time he has been acquitted. *See Kevorkian Faces New*

abortion, when the criminal law prohibits ethical doctors from providing patients the help they need to exercise fundamental life choices, patients turn to alternative, often inferior practitioners. Similarly, as with abortion, juries often are unwilling to enforce a blanket ban that condemns all those who seek to help patients exercise fundamental liberties.[37]

As with abortion services before legalization, the blanket ban against doctor-assisted suicide has created a two-tier system where the wealthy and privileged continue to exercise a fundamental right that they would deny to those they consider vulnerable to coercion. John H. Pickering, Senior Counsel to Wilmer, Cutler & Pickering and Counsel of Record for the *Amicus* American Geriatrics Society supporting the States in these cases, defends criminal sanctions against doctors who help terminally ill patients exercise choice in the face of death on the ground that we need to protect the most vulnerable segments of our society—the elderly, the poor and persons with disabilities.[38] No one could challenge this as a valid public policy. Such protectionist policies, however, create real world conundrums and double standards, as revealed by Mr. Pickering's frank admission that, "[a]t the same time I selfishly reserve my right to do in private what my family, my doctor and pastor and I, in loving consultation, voluntarily agree is best."[39] Respondents simply argue that everyone should have this "right" to choose that Mr. Pickering assumes is his.

If the States' position were accepted, an individual's ability to make certain highly intimate and personal choices—whether those choices are about procreation, abortion, or death—could be denied through a blanket ban that guards against some hypothetical threat posed by the exercise of that liberty. Moreover, fundamental liberty could be denied by a state if this Court were to defer to a state's judgment that a flat criminal ban is the best way to protect those who are

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Charges, Reuters, Ltd., Oct. 31, 1996.

[38] *See* Brief for *Amicus Curiae* American Geriatrics Society at 23-26.

[39] John H. Pickering, *The Continuing Debate Over Active Euthanasia*, 3 A.B.A. Bioethics Bull. 1, 15 (1994).

vulnerable to coercion. That cannot be the law.[40] A state does not advance its interest in prohibiting coercion by enacting a blanket ban that prevents free and voluntary decisions regarding highly personal and intimate matters, including decisions to hasten death in the face of terminal illness. Women's experience shows that such protectionist, blanket bans stifle authentic choice and force individuals to exercise their rights in unsafe and unregulated environments.

IV. THE STATES' CLAIM THAT CRIMINAL SANCTIONS MAY BE IMPOSED TO PROTECT LIFE OVER THE OBJECTION OF THE COMPETENT, TERMINALLY ILL PERSON WHO LIVES IT POSES A SPECIAL THREAT TO WOMEN.

The States claim that a blanket ban against doctor-assisted suicide advances a legitimate interest in preserving life.[41] Women have confronted similar arguments in the context of overbroad laws that infringe their fundamental right to exercise liberty over their own bodies and lives by choosing an abortion. In that context, this Court rejected the argument that the state has an uncompromising interest in protecting potential life that could justify the criminalization of all abortions.[42] This Court balanced the state's interest in

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[40] *See Casey*, 505 U.S. at 869 ("[l]iberty must not be extinguished for want of a line that is clear"); *Cruzan*, 497 U.S. at 355 ("[T]his Court cannot defer to any state policy that drives a theoretical wedge between a person's life, on the one hand, and that person's liberty or happiness, on the other. The consequence of such a theory is to deny the personhood of those whose lives are defined by the State's interests rather than their own.") (Stevens, J., dissenting).

[41] New York Br. at 20-26; Washington Br. at 34.

[42] *See Casey*, 505 U.S. at 857 ("our cases since *Roe* accord with *Roe*'s view that a State's interest in this protection of life falls short of justifying any plenary override of individual liberty claims").

protecting potential life against the interest of women in obtaining an abortion, and expressly held that the former must yield to the latter until the potential life at issue (the fetus) is viable. *Roe*, 410 U.S. at 162-63; *Casey*, 505 U.S. at 870-71. Moreover, even after the point at which a fetus becomes viable, a woman's liberty interest in preserving her own life or health overrides the state's interest in protecting the potential life of the fetus. *Roe*, 410 U.S. at 164-65; *Casey*, 505 U.S. at 846.

The States' asserted interest in protecting life must be balanced against the right of the terminally-ill to choose the time and manner of their own death. That balance tips decidedly in favor of the liberty interest of terminally ill patients. The state does not have an interest in preserving the life of all citizens at all times and under all situations. This Court recognized in *Cruzan* that a person has a constitutionally protected liberty interest in refusing unwanted medical treatment, 497 U.S. at 278, which means that the state's interest in protecting life cannot override the right of a person to hasten death by discontinuing a life support system. *Id.* at 288 ("Such forced treatment may burden that individual's liberty interests as much as any state coercion") (O'Connor, J., concurring). As with individuals whose lives are sustained by permanent life support systems, the state has no interest in preventing a competent, terminally ill person who is suffering severe and untreatable pain from hastening his or her own death.[43]

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[43] As Justice Stevens stated in *Cruzan*, "[h]owever commendable may be the state's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life". 497 U.S. at 356-57.

The States may have a legitimate interest in protecting life by preventing doctors, family members and others from coercing a terminally ill person to hasten his or her own death. Indeed, such an interest is fully consistent with the fundamental right of a terminally ill person to hasten death. By preventing coercion through the reasoned regulation of an individual's exercise of his or her liberty, a state can actually protect the fundamental right to hasten death by assuring that the right is exercised knowingly and voluntarily. *See supra* at 17-18. However, a law that criminalizes all doctor assisted suicide impermissibly infringes upon that right and relegates those who choose to exercise their right despite the state's prohibition to the realm of the uninformed, unsafe and unregulated.

V. THE CLAIM THAT THE CONSTITUTION PROHIBITS ONLY LAWS THAT ARE INVALID IN EVERY IMAGINABLE CIRCUMSTANCE IS INCONSISTENT WITH ESTABLISHED SUPREME COURT PRACTICE.

Before being reversed *en banc*, the three judge Ninth Circuit decision below held that the challenged statute must be upheld because "there were circumstances in which the statute could operate constitutionally, for example to deter suicide by teenagers or to prevent fraud upon the elderly".[44] The principle applied by the three judge panel was first articulated in *United States v. Salerno*, where the Court stated in dictum that a challenge to an overbroad law that denies constitutional liberty must be rejected unless "no set of circumstances exist under which the [law] would be valid". 481 U.S. 739, 745 (1987). That principle has no application in these cases and, in any event, is not the law.

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[44] *Compassion in Dying*, 49 F.3d at 591.

The rule articulated in *Salerno* has no application to these cases because Respondents challenge the laws at issue here as applied only to them and similarly situated people and seek a remedy to protect the constitutional right that they assert. In its *en banc* decision, the Ninth Circuit explicitly held that the blanket prohibition on physician assisted suicide is unconstitutional only insofar as it is "applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths".[45] The States do not challenge the Ninth Circuit's rejection of the *Salerno* rule or argue that these are appropriate cases for this Court to adopt the rule they urged below.

Further, the novel claim that courts may not recognize violations of fundamental constitutional liberty unless it is possible to say that the law challenged is unconstitutional in every conceivable circumstance is not, and has never been the law. For example, in *Griswold*, plaintiff physicians, on behalf of married patients, challenged a law that prohibited doctors from prescribing contraceptives for any patient.[46] If the peculiar new remedial notion urged by the States in the lower courts had been the law in 1965, the Court would have denied relief in *Griswold* because the blanket ban might have been

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[45] *Compassion in Dying*, 79 F.3d at 798. Similarly, the Second Circuit held "that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness. *Quill*, 80 F.3d at 718.

[46] The Connecticut statute challenged in *Griswold* read: "Any person who uses any drug, medical article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned". 381 U.S. at 480. Upon finding the law unconstitutional, the Court ordered that the criminal convictions be reversed and the law be struck. *Id.* at 485-86, 499.

constitutional as applied to unmarried teenagers or to doctors prescribing contraceptives that were, for example, ineffective and dangerous. That was not the approach adopted in *Griswold*. Rather the Court considered the claim presented to it, held that the law was unconstitutionally overbroad and reversed the criminal convictions of the parties before it.[47]

The wiser and accepted course in cases challenging broad criminal statutes that violate constitutional liberty is simply to hold that the law is unconstitutional as applied to the parties before the Court and those who are similarly situated or to strike the law as unconstitutional on its face. This allows state legislatures to craft laws that protect legitimate state concerns, without overbroad infringement of constitutional liberty. It invites state and federal legislatures to "participate in a dialogue" and to act to develop more refined approaches that both respect fundamental individual choice and protect against coercion and abuse.[48]

This radical concept that a court may not protect a violation of constitutional liberty unless the challenged law is unconstitutional in every conceivable circumstance has been applied by some judges in cases challenging restrictive abortion laws that plainly violate the rights affirmed in *Casey*.[49] It would, if adopted, extend the substantive rule of

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[47] The Connecticut Court of Errors set aside the defendants' convictions and remanded to the trial court for further proceedings consistent with the judgment of the Court. *Griswold v. Connecticut*, 213 A.2d 525 (1965). The Connecticut legislature repealed the challenged laws. 1969 Conn. Pub. Acts 282, § 214 (eff. Oct. 1, 1971).

[48] Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1198, 1204 (1992).

[49] *Ada v. Guam Soc'y of Obstetricians & Gynecologists*, 506 U.S. 1011 (1993) (Rehnquist, C.J., White, J., and Scalia, J., dissenting from the denial of *certiorari*); *Barnes v. Moore*, 970 F.2d 12, 14 & n.2 (5th Cir.), *cert. denied*, 506 U.S. 1021 (1992).

deference to state discretion to regulate economic affairs to cases in which the Court has found that a law burdens a fundamental personal liberty without justification. It would use the remedial phase of constitutional adjudication to enshrine substantive constitutional principles wholly deferential to state power.[50] As Justice Stevens has noted, "*Salerno*'s rigid and unwise dictum has been properly ignored in subsequent cases".[51] Certainly it has no application to these cases in which Respondents challenge the application of absolute bans that deny them their fundamental rights of liberty and serve no legitimate state purpose.

As the Court recognized in *Cruzan*, "in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" 497 U.S. at 277-78 (citing *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)).

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[50] Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 Maryland L. Rev. 292, 324-341 (1996).

[51] *Janklow v. Planned Parenthood, Sioux Falls Clinic*, 116 S. Ct. 1582, 1583 (1996) (memorandum opinion concurring in denial of petition for *certiorari*).

CONCLUSION

For the foregoing reasons, the decisions of the Courts of Appeals should be affirmed.

December 10, 1996

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Nos. 95-1858 and 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General
of the State of New York, *et al.*,
Petitioners,

v.

TIMOTHY QUILL, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF STATE LEGISLATORS IN SUPPORT OF RESPONDENTS

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Interest of Amici[1]

Amici are members of the legislatures of sixteen States, including New York and Washington. Within our federal system, amici recognize that their obligations as representatives of the People of the several States must coexist with their sworn duty to uphold the Constitution of the United States. Mindful of that duty, amici seek a ruling in this case that preserves both the essential attributes of state sovereignty and the supremacy of federal law. With due respect, the position advocated in this Court by the petitioners and their amici distorts our system of dual sovereignty beyond recognition. Their position implies that to protect a constitutional right is to interfere with state sovereignty. However, especially in a case such as this one -- in which significant room exists for reasonable state regulation that does not infringe the core right asserted -- protection of the constitutional right preserves the proper balance of authority between representative government and constitutional safeguards.

Statement of the Case and Summary of Argument

The States of New York and Washington impose criminal liability on physicians who provide death-inducing medication to mentally competent, terminally ill patients seeking to assert some measure of autonomy over the waning months, weeks or days of their lives. *See* N.Y. Penal Law § 120.30 (McKinney 1987); Wash. Rev. Code Ann. § 9A.36.060 (West 1988). The Courts of Appeals for the Second and Ninth Circuits held that these statutes, respectively, violate the Equal Protection and Due Process Clauses of the Fourteenth Amendment, as applied to physicians and patients in respondents' circumstances. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

Although the state prohibitions at issue here take the nominal form of a failure to provide an exemption from the States' general prohibition on assisting suicide, these cases no more involve an asserted "right to suicide" than an as-applied challenge to a State's

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[1] The parties' letters consenting to the filing of this brief have been filed with the Court. *See* Sup. Ct. R. 37.3. A list of the amici appears in Appendix B to this brief.

failure to exempt pre-viability abortions from its prohibition on homicide would involve a "right to murder." Rather, these cases raise the question whether the States may require that an individual's final stage of life be filled with suffering without proffering any stronger justification for failing to adopt more measured safeguards than that such complete prohibitions were "laid down in the time of Henry IV." Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897).

This Court has long recognized that the State must offer some special justification for seeking to control central, intimate, personal decisions. *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Indeed, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the Court assumed "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," including lifesaving food and water. *Id.* at 278. That assumption was an express condition of the concurrence of the fifth Justice. *See id.* at 289 (O'Connor, J., concurring).

From the perspective of a suffering patient, the interest at stake in seeking medication for the purpose of causing death does not differ from the interest at stake for a patient who, for the purpose of causing death, seeks to discontinue a course of medical treatment. To be sure, there are circumstances in which the State may distinguish between, on the one hand, refusing medical treatment and, on the other, bringing about death through other means. But it hardly follows that the State may therefore employ the distinction under *all* circumstances. At the very least, the State must offer some substantial reason why the ability of a mentally competent, terminally ill patient to seek a physician's assistance in ending his or her suffering should depend upon the fortuity of whether he or she happens to be undergoing some course of treatment the discontinuation of which would cause death.

The fact that the State has traditionally had the power to prohibit assisted suicide cannot, by itself, justify infringing the liberty of respondents. This Court has consistently rejected the claim that constitutional liberty should be measured by reference to "the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." *Michael H. v. Gerald D.*, 491 U.S. 110, 127 n.6 (1989) (Scalia, J., joined by Rehnquist, C.J.). Instead, fidelity to the enduring constitutional

principles of this Court's prior cases requires that the liberty asserted be measured against those very principles. *See id.* at 132 (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

As this Court made clear in *Casey*, although the case for a woman's constitutional liberty to decide whether to have an abortion is a clearly convincing one, abortion nonetheless presents a difficult question because the State has a strong interest in the life of the fetus to be weighed against the woman's liberty. 505 U.S. at 871. By contrast, no interest of comparable dimension, and certainly no interest sufficient to justify an outright ban on the decisions at issue here, can be advanced by the State.

Nevertheless, the State has valid interests that justify careful regulation of the decision of a mentally competent, terminally ill patient to seek the assistance of a physician in carrying out his or her wishes about how to live life's final days. These interests include ensuring: that the patient is competent to make a decision; that the patient truly wishes to die; that the decision is not the product of coercion or undue pressure; that the patient has been made aware of alternatives that would ease his or her suffering; and that state recognition of the limited right sought here would not send a broader signal condoning suicide in general. Because careful regulations can be crafted to serve each of these legitimate interests (as well as others), the States' complete prohibitions must be deemed undue intrusions.

Carefully drawn regulations would also be more effective than the complete bans in furthering the State's legitimate ends. Notwithstanding laws like those at issue here, many physicians have in fact helped their patients to die;[2] yet "[t]here is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." *Compassion in Dying*, 79 F.3d at 811. Official criminalization assures that doctors who render aid in dying act in secrecy, or worse, that many patients seek out back-alley assistance from the unscrupulous. In this sense, current law in New York, Washington and most other States closely resembles the Dutch model of tacit approval of an illegal act. *See*

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[2] In a recent poll, 20% of the doctors surveyed admitted to having helped a patient to die. *See Poll Shows that 1 in 5 Internists has Helped a Patient Die*, Am. Med. News (Mar. 16, 1992) at 9.

Brief of the American Medical Association, *et al*, at 12-13 (No. 95-1858) (conceding that physician-assisted suicide is illegal but not prosecuted under Dutch law). The divergence between *de jure* and *de facto* rules of law that characterizes the Netherlands,[3] is an inappropriate model for the United States. Yet that is the regime that petitioners ask this Court to validate.

Finally, this Court should not reverse the decisions below in the vain hope of avoiding difficult line-drawing decisions. A decision to reverse would call for the drawing of seemingly purposeless lines and the creation of bizarre categories; for example, it would require the Court to explain the sense in which a doctor's violent removal of a large tube from a patient's esophagus is "inaction," while the patient's self-administration of a pill constitutes "action" by the doctor. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Perhaps such seemingly arbitrary distinctions are permissible when all that is at stake is regulation of purely economic transactions, but not when the case involves intimate, personal, self-defining decisions -- as these cases undoubtedly do.

Argument

I. The Right of a Mentally Competent, Terminally Ill Adult to the Assistance of a Willing Physician in Carrying out a Decision About How to Live Life's Final Days is an Essential Aspect of the Liberty Protected by the Due Process Clause of the Fourteenth Amendment.

In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), a majority of this Court reaffirmed "the essential holding" of *Roe v. Wade*, 410 U.S. 113 (1973). *Casey*, 505 U.S. at 846. In the course of explaining the basis for its decision, this Court made clear its continued adherence to the century-old principle that the Due Process Clause of the Fourteenth Amendment protects "all fundamental rights comprised within the term liberty," *Whitney v. California*, 274 U.S. 357, 373 (1927) (Brandeis, J., joined by

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[3] *See also* van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717, 731 (1990) (noting that Dutch law makes possession of marijuana and hashish a crime, but other principles prevent enforcement of the prohibition).

Holmes, J., concurring), against undue state interference. *See Casey*, 505 U.S. at 846-47 (citing *Mugler v. Kansas*, 123 U.S. 623, 660-61 (1887), *Daniels v. Williams*, 474 U.S. 327, 331 (1986), and *Whitney*). The *Casey* Court reaffirmed that the Due Process Clause protects not only the rights expressly enumerated in the Bill of Rights, nor only "those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified." 505 U.S. at 847. "It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter." *Id.* If this Court's liberty jurisprudence is to remain principled, that realm must include the decision of a mentally competent terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days.

This Court's decision in *Casey* rested on more than just the principle of *stare decisis*. In the first portion of the *Casey* opinion, the Court unhesitatingly re-affirmed the existence of a constitutionally inviolable realm of individual conscience. To the extent that the *Casey* Court relied on the principle of *stare decisis* as a supplement to its basic reasoning, it did so for purposes of assessing the State's countervailing interest in fetal life. As the Court stated, "[t]he weight to be given [the] state interest [in fetal life], not the strength of the woman's interest, was the difficult question faced in *Roe*." 505 U.S. at 871.

The individual right claimed in the present cases falls squarely within the zone of liberty that the *Casey* Court reaffirmed without reliance upon the doctrine of *stare decisis*. The *Casey* majority reaffirmed the constitutional theory and practice guaranteeing protection for marriage, procreation, contraception, family relationships, child rearing, and education, 505 U.S. at 851, stating that

> [t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id.

Let there be no mistake. These carefully chosen words from one of the century's most closely watched and hard-fought cases do not bear some mere accidental relation to the cases now before the Court. A terminally ill patient who needs the aid of a willing physician to end his or her suffering and to preserve what the patient believes to be his or her dignity faces a critical self-defining choice. To hold that such a decision is qualitatively less intimate, personal or central than decisions about where to send one's child to school, *see Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923), would do irreparable damage to this Court's commitment to principled exposition of constitutional rights.

Even before *Casey's* careful reaffirmation of the constitutional basis for a protected zone of liberty, this Court made clear that end-of-life decisions implicate that protected zone. In *Cruzan v. Director, Missouri Dept. Of Health*, 497 U.S. 261 (1990), the Court began its analysis by recognizing that its prior cases support "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment . . . ." *Id.* at 278. The majority opinion assumed for purposes of that case that a competent person has "a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* Justice O'Connor -- who provided the critical fifth vote for the *Cruzan* majority -- did not merely assume such a right. Her concurrence depended on the understanding that "the liberty guaranteed by [the Due Process Clause] must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289 (O'Connor, J. concurring). *Accord Washington v. Harper*, 494 U.S. 210, 221-22 (1990) (in the course of upholding state procedural scheme, stating "[w]e have no doubt that, in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment").

To be sure, *Cruzan* used the language of "liberty interests" rather than "fundamental rights," 497 U.S. at 278, but then *Casey* similarly eschewed the fundamental rights label. More important than the precise doctrinal pigeonhole into which one places these cases is the fact that both *Casey* and *Cruzan* recognized that when

the State seeks to infringe basic liberties, it must show that doing so will advance interests of comparable weight. *See Casey*, 505 U.S. at 875-76; *Cruzan*, 497 U.S. at 279 ("'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Because of the exceedingly strong precedent supporting recognition of the right asserted here, petitioners resort to elaborate but unavailing argumentative gymnastics in their efforts to distinguish this Court's earlier decisions. They contend that the right recognized by a majority of this Court in *Cruzan* is only a right to refuse the imposition of unwanted medical treatment in the form of artificial life support or hydration and nutrition, rather than what they term *active* assistance. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Petitioners offer two kinds of reasons for this distinction. First, they point to a variety of public policies which, they allege, are undermined by permitting so-called *active* death-hastening measures by doctors. Second, they contend that as an historical matter, the common law right given constitutional recognition in *Cruzan* does not extend beyond refusing or discontinuing medical treatment. Neither kind of reason provides a constitutional basis for the distinction proffered.

By invoking public policies that supposedly would be offended by permitting "active" death-hastening measures, petitioners and their amici seek to obscure the fact that *from the perspective of the individual*, the interest of a mentally competent, terminally ill adult in obtaining a physician's "active" aid in dying is identical to the interest in terminating life-support. This Court must therefore measure the public policies offered in support of the laws under review here *against* the right asserted by the plaintiffs, rather than double-counting these public policies by incorporating them *into* the definition of the right. If the State could show that its asserted policies justified overriding respondents' strong liberty interest, that would provide a constitutional basis for denying recognition to the right. However, "[w]hen the factors that provide the state's possible justifications for its regulation are automatically incorporated into the initial definition of a liberty, the fundamental nature of that liberty inevitably vanishes." Tribe & Dorf, On Reading the Constitution 107 (1991). As will be shown below, the proffered state interests cannot justify the blanket prohibitions before this

Court. Before addressing the state interests, however, this Court must examine the intended impact of the laws on the individuals subject to them. *Cf. Casey*, 505 U.S. at 894 ("The analysis does not end with the [persons burdened by the law]; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects.") That impact can only be described as enormous.

Viewing the relevant constitutional right recognized by this Court's prior cases as one of personal autonomy makes clear that the right encompasses the cases now before the Court. No volume of citations or lawyerly argument could refute the obvious fact that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. Washington*, 79 F.3d 790, 813 (9th Cir. 1996) (en banc).

Indeed, the autonomy interest of a mentally competent, terminally ill patient in physician assistance in carrying out his or her decision about how to live life's final days would appear to be stronger than the right recognized by a majority of this Court in *Cruzan*. Respecting the wish of a person in a vegetative state to have life-sustaining medical treatment withdrawn invariably means respecting that person's *past* wishes -- typically formed at a time when he or she viewed the possibility of ending up in such a state as hypothetical. By contrast, a mentally competent, terminally ill patient acts with full knowledge of the reality and immediacy of the consequences. For the State to prohibit aid in dying for him or her is to interfere with the individual's autonomy in the here and now.

The right of a mentally competent terminally ill patient to physician assistance in carrying out his or her decision about how to live life's final days is also an exemplar of bodily integrity. Petitioners assert that the right to bodily integrity merely prohibits the State from imposing unwanted intrusions on the person. *See* Brief for the Petitioners at 30 (No. 96-110); Brief for Petitioners Vacco and Pataki at 9-11 (No. 95-1858). The act/omission distinction thus advanced is incoherent in the present cases, as a comparison with the abortion decisions reveals.

This Court has recognized the abortion right as grounded, *inter alia*, in bodily integrity. *See Casey*, 505 U.S. at 857. Yet the act of abortion constitutes affirmative intervention (by a physician, it should be noted) with a pregnant woman's "natural" state. Abortion

restrictions interfere with the right of bodily integrity because they have the effect of requiring the physical privations of pregnancy -- even though those privations occur as a natural result of the woman's condition. In the same way, prohibitions on physician assistance in the carrying out of end-of-life decisions interfere with the right of bodily integrity because they have the effect of requiring the physical and emotional privations of the illness from which the patient suffers -- even though those privations occur as a natural result of that illness. This Court's recognition that the abortion right is rooted in the right to bodily integrity thus inevitably implies that the right of a terminally ill patient to assistance in carrying out his or her decision about how to live life's final days is rooted in the same right to bodily integrity.[4]

Petitioners rely on a discredited narrow form of historical analysis in their efforts to carve out an ad hoc exception to this Court's liberty jurisprudence. They contend that the mixed historical pedigree of the constitutional right claimed here precludes its recognition. *See* Brief for the Petitioners at 21-25 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11-13 (No. 95-1858). In its landmark decisions recognizing constitutional protection for liberty and equality, this Court has never considered itself bound by the kind of narrow historicism that petitioners and their amici contend should guide the decision in the present cases. The consistency of racial segregation with equal protection of the laws was widely assumed at the time of the adoption of the Fourteenth Amendment, *see, e.g.*, Hovenkamp, *The Cultural Crises of the Fuller Court*, 104 Yale L.J. 2309, 2338-40 (1995), yet that did not prevent a contrary conclusion in *Brown v. Board. of Educ.*, 347 U.S. 483 (1954). Similarly, as the *Casey* Court recognized, in *Loving v. Virginia*, 388 U.S. 1 (1967), eight Justices found that anti-miscegenation statutes violated the fundamental liberty to marry, notwithstanding the widespread acceptance of such prohibitions at the time of the adoption of the Due Process Clause and for a long

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[4] The United States attempts to distinguish *Roe* and *Casey* on the ground that abortion prohibitions produce the responsibilities of parenthood as well as the suffering associated with pregnancy. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 16-17 (No. 96-110). But that factor has no independent weight, for if it did, then a man would have a constitutional liberty in forcing his mate to have an abortion, and biological parents would have a similar liberty to commit infanticide.

time thereafter. *See Casey*, 505 U.S. at 847-48 (citing *Loving*, 388 U.S. at 12).[5]

Of perhaps greatest significance, the *Cruzan* Court itself did not inquire into whether the common law traditionally protected a specific right to the removal of nutrition and hydration, nor did it even accord significant weight to the contemporary treatment by state legislatures of that precise act. After canvassing the evolving approach in the state courts, this Court concluded in broad terms:

> As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones.

497 U.S. at 277. The Court then exercised its own judgment in assuming that this right included rejecting nutrition and hydration. *See id.* at 279.

Justice O'Connor's crucial concurring opinion in *Cruzan* used

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[5] Petitioners in No. 96-110 attempt to distinguish *Loving* by noting that "'[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness,' even though the right to inter-racial marriage has no similar historical pedigree. Brief for the Petitioners at 22 (quoting *Loving*, 388 U.S. at 12). But this point merely underscores the flaw in petitioners' basic mode of analysis. The *Loving* Court found it sufficient that the very specific right to inter-racial marriage, although itself not "deeply rooted in this nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), was an instance of the broader historical tradition affording protection to marriage and other intimate associations. So too here, although the very narrow right of a mentally competent, terminally ill patient to the assistance of a willing physician in carrying out a decision about the end of life has not been the subject of positive legal protection, it is an instance of the broader historical and legal tradition affording protection to important intimate and personal decisions. Petitioners are surely right that "[t]he degree of specificity with which the asserted right is described is important and may be determinative of the extent to which the claim of constitutional protection is recognized." Brief for the Petitioners at 19 (No. 96-110) (citing Tribe and Dorf, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990)). Yet they offer no justification for selecting the extremely narrow level at which they focus. By contrast, amici respectfully submit that we have focused at the proper level because, from the perspective of the individual, the right respondents claim commands the same or greater respect as the right recognized in *Cruzan* and this Court's other cases in this area.

the same mode of analysis. After locating a broad right to refuse medical treatment in the Court's prior decisions, Justice O'Connor concluded: "The State's artificial provision of nutrition and hydration implicates identical concerns. Artificial feeding cannot readily be distinguished from other forms of medical treatment." *Id.* at 288 (O'Connor, J., concurring). Thus, in the decision of this Court that most closely resembles the present cases, the Court did not employ the narrow historical methodology that petitioners and their amici advocate. Petitioners and their amici seek to replace this Court's tradition of reasoned elaboration with the oft-rejected view that this Court should only recognize the most specific rights protected by an historical tradition. *See Michael H. v. Gerald D.*, 491 U.S. 110, 132 (1989) (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

Similarly unavailing are the efforts of petitioners and their amici to invoke contemporary state practice as a basis for denying respondents' claim of constitutional right. It is that very practice that is under challenge here. Moreover, as the en banc panel of the Court of Appeals for the Ninth Circuit noted below, there is considerable public support for a carefully regulated right of mentally competent terminally ill patients to physician assistance in carrying out their decisions about how to live life's final days. *Compassion in Dying*, 79 F.3d at 810 (citing public opinion polls and the results of the 1994 Oregon referendum). At the same time, even where such assistance is prohibited, the urgency of reform efforts is dampened by the nearly complete lack of enforcement.[6]

Standing alone, current social attitudes and trends in the positive law of the States might not be sufficient to establish a terminally ill patient's constitutional right to autonomy in decisions about how to live life's final days. But these trends and attitudes do not stand alone. Recognition for the right rests on the solid foundation of principled application of decisions this Court has already rendered.

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[6] Apparently conceding the point, petitioners' amici grasp at straws by asserting that "the States do enforce their assisted suicide laws." Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 21. This general proposition, however, has no bearing on the specific issue now before the Court, as petitioners' amici cite no case involving a doctor assisting a terminally ill patient. *See id.* at 21 n.15 (citing, *inter alia*, two cases involving teenage suicide pacts, *see In Re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991)).

At the very least, current social attitudes and trends in state positive law do nothing to undermine the case for the constitutional right advanced here. Indeed, they appear to strengthen that case.

If this Court's liberty doctrine is to remain a jurisprudence of principle and not a mere assortment of ad hoc judgments, it must recognize that the right of a mentally competent terminally ill patient to seek assistance in carrying out his or her decision about how to live life's final days lies at the very core of the constitutionally protected personal autonomy and bodily integrity that this Court has long recognized. Thus, whatever arguments petitioners and their amici advance to distinguish that right must, at the outset, be of sufficient weight to overcome an individual interest of the highest order. As will be shown below, although the State has legitimate regulatory interests in this area, none of them remotely justifies an absolute ban.

II. The Equal Protection Clause of the Fourteenth Amendment Provides an Alternative Basis for Affirming the Rulings Below, but Whether Viewed as a Question of Due Process Liberty or Equal Protection, the Central Question in these Cases is Whether the States have Offered a Sufficient Justification for Overriding Personal Autonomy.

Hornbooks of constitutional law state that laws challenged under the Fourteenth Amendment as infringing rights protected by the Due Process or Equal Protection Clause will be subject to heightened scrutiny if they infringe fundamental rights. *See, e.g.*, Nowak and Rotunda, Constitutional Law § 11.7, at 399 (5th ed. 1995). Otherwise, legislation not employing illicit classifications is subject only to the deferential rational basis test. *See id.*, § 11.4, at 383. Although this framework has the virtue of simplicity, it has two important limitations. First, its on/off character requires the courts to draw somewhat arbitrary lines between fundamental rights and lesser interests. Second, it seems to require the courts to treat all laws affecting fundamental rights with equal suspicion, even though they might serve quite different purposes. For these reasons, it is fair to say that this Court's Fourteenth Amendment jurisprudence was never quite so simple as the hornbooks would suggest. *See Zablocki v. Redhail*, 434 U.S. 374, 386 (1978). *Cf. San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 98-110

(1973) (Marshall, J., dissenting); Note: *Justice Stevens' Equal Protection Jurisprudence*, 100 Harv. L. Rev. 1146 (1987).

In *Casey*, the joint opinion of Justices O'Connor, Kennedy, and Souter announced that abortion regulations would be judged according to an undue burden test, under which laws with the purpose or effect of emplacing substantial obstacles in the way of a decision to have an abortion would be held invalid. 505 U.S. at 877. Whether the undue burden test reflects a judgment as to how the strict scrutiny standard ought to apply in the abortion context, *see* Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 272 n.153 (1994), or whether it represents a more general approach to classifying various kinds of burdens on individual rights, *see* Dorf, *Incidental Burdens on Fundamental Rights*, 109 Harv. L. Rev. 1175, 1219-32 (1996), is perhaps an interesting academic question. The import of *Casey* for the present cases, however, is clear: recognition of the right of a mentally competent, terminal patient to seek the assistance of a willing physician in carrying out his or her decision about how to live life's final days does not automatically lead to the invalidation of all laws regulating that decision. Rather, the Court must undertake a careful examination of the ends and means of state regulation.

In its decision below, the Court of Appeals for the Second Circuit believed that it was constrained not to recognize "new" constitutional rights under the Due Process Clause. *See Quill*, 80 F.3d at 724-25. That reluctance was based in part on an overly broad reading of *Bowers v. Hardwick*, 478 U.S. 186 (1986), *see Quill*, 80 F.3d at 724-25, a case whose core holding has been eroded by this Court's decision in *Romer v. Evans*, 116 S. Ct. 1620 (1996), and whose methodology has not been in evidence for quite some time, even in Due Process Liberty cases. The lead opinion in *Casey*, for example, does not even cite *Hardwick*. What remains of *Hardwick* is perhaps a cautionary note with which no sensible student of constitutional law could disagree – that the Court should tread lightly in defining zones of liberty under the Due Process Clause. Affirming the judgments below would not in any way contravene this caution.[7]

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[7] The Second Circuit also believed itself constrained to avoid a ruling under the Due Process Clause because it is a lower court. *See Quill*, 80 F.2d at 725 ("Our position in the judicial hierarchy constrains us to be even more

More fundamentally, the Second Circuit's own analysis of the Equal Protection issue belies any concern that respondents seek a "new" liberty. The central basis for the Second Circuit's ruling is that the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days cannot be rationally distinguished from the right of a similarly situated patient to refuse life-saving medical treatment. *See id.* at 725-31. Whether the Court recognizes this linkage as a matter of Due Process or Equal Protection is of much less significance than that the Court recognize its obligation to apply its precedents in a principled manner. *See Bolling v. Sharpe*, 347 U.S. 497, 499-500 (1954) (holding that the Fifth Amendment Due Process Clause prohibits arbitrary classifications, a category largely coextensive with those prohibited by the Fourteenth Amendment's Equal Protection Clause). Distinctions that bear on so intimate and central a choice as the one at issue here must, at the very least, be supported by more than the State's conclusory assertion that it wishes to extend protection to the choice in some circumstances, but not in others.

The Court need not, and probably should not, adopt a doctrinal approach to be used to test all state regulations of, and distinctions regarding, the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days. To decide this case it is sufficient to ask the States to come forward with some substantial justification for the complete bans at issue. As will be shown in the next section, the States fail this minimal requirement.

Nevertheless, should this Court decide to announce a doctrinal framework applicable to future cases, amici respectfully suggest that the undue burden test elaborated by the joint opinion in *Casey* provides the appropriate framework. That test properly recognizes that not all regulations governing the exercise of a right infringe that right. *See Casey*, 505 U.S. at 874-75; *See also Zablocki*, 434 U.S. at 386 (denying that "every state regulation which relates in any way to the incidents of or prerequisites for marriage must be subjected to rigorous scrutiny.") The undue burden standard of *Casey* requires that only laws with the purpose or effect of placing a substantial

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reluctant than the Court to undertake an expansive approach in this unchartered area."). That constraint, by definition, does not apply to this Court.

obstacle in the path of the right's exercise should be deemed infringements of that right. Whether this standard applies to *all* constitutional rights is a puzzle well beyond the scope of this case. For present purposes, it is sufficient to note that the State has related interests in regulating decisions about abortion and the end of life, so that it would be appropriate to apply the undue burden test here.[8]

Of course, a flat ban on patient choice quite obviously has both the purpose and effect of placing a substantial -- indeed an insurmountable -- obstacle in the path of the exercise of the right asserted here. Thus, the only real question is whether petitioners can come forward with a justification for this severe burden. As will be shown in the next section, they cannot. Whether the Court applies traditional heightened scrutiny or a standard more akin to a balancing test, the measures at issue here simply cannot be sustained.

III. No State Interest Justifies a Blanket Prohibition on a Mentally Competent, Terminally Ill Patient's Exercise of the Right to the Assistance of a Willing Physician in Carrying out his or her Decision About how to Live Life's Final Days.

Recognizing the constitutional dimension of a mentally competent patient's decision to seek a physician's assistance in carrying out his or her decision about how to live life's final days does not, of course, preclude all regulations designed to further the State's important countervailing interests. As respondents have conceded throughout the proceedings below, and as both the Courts of Appeals for the Second and Ninth Circuits recognized, the State does have important regulatory interests. Nevertheless, the mere recitation of state interests cannot be permitted to displace constitutional analysis. In the case of abortion, after all, the State validly asserts an interest in what many people consider to be innocent human life; yet in *Casey*, a majority of this Court understood that even that exceptionally important state interest does

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[8] Thus, there is no reason to conclude that affirming the results below would mean that all "state supervision and regulation in this area will be subject to exacting judicial review." Brief of Amicus Curiae State of Oregon in Support of Petitioners at 1 (No. 96-110).

not invariably override the liberty protected by the Due Process Clause.

The state interests most frequently cited by petitioners and their amici in support of the laws challenged here include: (1) protection and preservation of life, *simpliciter*; (2) prevention of suicide; (3) prevention of coercion and undue influence; (4) prevention of the devaluation of the lives of the handicapped and other disadvantaged members of society; and (5) maintaining the ethical integrity of the medical profession. For completeness, it will be shown below that each of these interests can be readily accommodated by measures falling well short of the outright bans under review here. The Court should not, however, miss the forest for the trees. None of the state interests advanced here weigh as heavily as the interest in innocent human life at stake in the abortion context.[9] If, as the Court has correctly held, that interest cannot justify an outright ban on all abortions, surely the less weighty state interests advanced here cannot justify the outright bans on the exercise of a mentally competent, terminally ill adult's right to seek the assistance of a physician in carrying out his or her own decision about how to live life's final days.

[9] The fact that a fetus is not a person within the meaning of the Fourteenth Amendment, *see Roe v. Wade*, 410 U.S. 113, 156-59 (1973), does not mean that the State has no interest in protecting the fetus. To the contrary, the State has a very strong interest in fetal life, even before viability, *see Casey*, 505 U.S. at 872, but even that very strong interest is insufficient to override the woman's liberty. Petitioners' amici would infer from *Roe*'s conclusion about the constitutional status of the fetus the proposition that in order for respondents to prevail in this Court, they must show that terminally ill patients are not persons within the meaning of the Fourteenth Amendment. *See* Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 7-8. Yet the very fact that terminally ill patients *are* persons within the meaning of the Fourteenth Amendment gives rise to their rights under the Due Process and Equal Protection Clauses. For the State to override those claims it must proffer an interest *to be weighed against them*.

A. The State's Interest in Protection and Preservation of Life, *Simpliciter*, Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

This Court's decision in *Cruzan* precludes a conclusion that the State's abstract interest in life can outweigh a patient's right of autonomy in end-of-life decisions. In *Cruzan*, this Court appeared to divide over whether the State may assert a legitimate interest in life, apart from -- and in opposition to -- the wishes of the person whose life is at stake. Speaking for three members of the Court, Justice Brennan averred that "the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment." 497 U.S. at 313 (Brennan, J., dissenting). A fourth member, Justice Stevens, agreed. *See id.* at 331 (Stevens, J., dissenting) (finding "the State's abstract, undifferentiated interest in the preservation of life" an inadequate basis for overriding patient choice). The majority opinion of Chief Justice Rehnquist stated that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Id.* at 282 (opinion of the Court).

Although amici would respectfully suggest that the *Cruzan* dissenters' view is to be preferred,[10] even the view espoused by the Chief Justice in *Cruzan* requires that the individual right be given greater weight than the State's abstract interest in life. The *Cruzan* Court addressed a question that arises amid uncertainty. The Court faced the question of how to balance societal interests against individual choice when the result of individual choice is unknown. The Court determined that, in the light of such uncertainty, the State's abstract interest in life, combined with other legitimate state interests, can justify a procedural mechanism requiring clear and

[10] *See* Dworkin, Freedom's Law: The Moral Reading of the American Constitution 140-43 (1996) (arguing that interests that are detached from any person's well-being ought not be permitted to override an actual person's concrete wishes on matters of self-defining religious or spiritual importance).

convincing evidence of patient intent. Nevertheless, the fact that the Court assumed that a competent patient has a constitutional right to refuse life-saving medical treatment -- a point that was a necessary condition for Justice O'Connor's crucial concurrence -- means that even the *Cruzan* majority assumed that the State's abstract interest in life cannot justify overriding patient choice when that choice is clear.

To say that a competent patient would have the right to refuse life-saving medical treatment is to say that *no state interest* is sufficiently strong to overcome that right as a categorical matter. Thus, whether one deems the State's abstract interest in life an illegitimate basis for regulation -- as the *Cruzan* dissenters did -- or as a legitimate interest that justifies some state regulation -- as the Chief Justice's opinion in *Cruzan* did -- there is no basis for concluding that the State's abstract interest in life can justify entirely overriding patient choice. The interest simply does not outweigh the individual liberty at stake.

The premise that the State's abstract interest in life does not justify overriding individual autonomy does not in any way depend upon the supposed distinction between withdrawal of medical treatment and the prescription of life-ending medication. Whatever the merits of that distinction for other purposes, the State's abstract interest in life is identical in both cases. In either case, the state interest is in the preservation of life. Any measure that hastens the end of life, whether characterized as *action* or *inaction*, poses a threat to the State's abstract interest in life. Thus, the attempts by petitioners and their amici to characterize the right at stake in this case as involving "active" assistance simply have no relevance to the question whether the State's abstract interest in life overrides patient autonomy. That question was resolved in the negative by the course of reasoning in *Cruzan,* and the resolution there fully applies here.

This is not to say, however, that the State is powerless to take measures to further its abstract interest in life. As the joint opinion of Justices O'Connor, Kennedy, and Souter stated in *Casey:*

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules

> and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself.

505 U.S. at 872. So too may the State seek to ensure that a decision so momentous and irreversible as to forego even a short period at the end of life is a fully informed one. To this end, reasonable state laws that provide a framework in which this decision is made, should be upheld. Indeed, properly understood, *Cruzan's* approval of a heightened evidentiary threshold safeguards just such an interest -- ensuring that patient choice is in fact respected.

In the context of the present cases, the State can pursue its abstract interest in life by measures short of a total ban on patient choice. Proposals recently introduced in the legislatures in many States provide a variety of permissible means of addressing the State's legitimate concern that the patient himself or herself has given adequate attention to the sacredness of all life, and has considered the available alternatives. These proposals, which are summarized in Appendix A to this brief, include requirements that two financially independent physicians certify the patient's mental competence, that the patient make repeated statements of his or her wish to end life, that the patient be provided with information about treatment options, including palliative care, as well as other safeguards. This Court need not and should not hold that any of these particular provisions is constitutionally required to recognize that by removing *all choice* from patients, the New York and Washington laws go too far.

B. The State's Interest in Prevention of Suicide Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Perhaps none of the arguments presented by petitioners and their amici has the same emotional appeal as the contention that affirming the decisions below would set the Court sliding down the

slippery slope to sanctioning suicide as a constitutional right. The claim is specious. Principles of judicial restraint counsel the Court to craft a narrow ruling in this case, one that addresses the facts before it, while leaving some line-drawing questions for another day.[11] Furthermore, even if the Court decides to tackle such questions here, affirming the judgments below in no way entails recognizing a general constitutional right to suicide. Indeed, examination of the state interest that justifies preventing suicide strengthens the conclusion that the cases before the Court present a very different question.

Apart from the State's abstract interest in life, the State's principal interest in preventing suicide is to preserve the actual life of persons who would otherwise commit suicide. The State may assume that a person who has not been diagnosed with a terminal illness will derive fulfillment from years of future life -- even if he or she does not presently realize this to be so. In preventing suicide by persons who are not terminally ill, the State seeks to protect the future self against the potentially rash judgment of the present self.

In contrast, a patient suffering from a terminal illness has no expectation of sustained future life. As a result, the State's interest in protecting the future self against the decision of the present self is greatly diminished. It is frankly grotesque for the State to justify overriding the patient's will on the ground that the patient would benefit from several weeks or months of physical deterioration or mental decomposition. The difference between preventing suicide generally and preventing a terminally ill patient from receiving a willing physician's aid in dying is the difference between a tolerable degree of paternalism in the interest of a person's enjoyment of life and what, from the perspective of the patient, can only be described as sadism.

"Liberty must not be extinguished for want of a line that is clear." *Casey,* 505 U.S. at 869. It certainly should not be extinguished because of imagined ambiguities that lie down a road

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[11] It is ironic that petitioners and their amici invoke the specter of judicial activism, while at the same time urging that the Court must issue a broad, categorical ruling. The charge of activism has been most deserved when the Court has reached out to decide questions not squarely before the Court. *See* Ginsburg, *Speaking in a Judicial Voice,* 67 N.Y.U. L. Rev. 1185 (1992). It is plain that in this case, petitioners and their amici seek a broad, categorical ruling, while respondents and their amici urge the Court to proceed with caution.

upon which this Court need never tread. The general state interest in preventing suicide has no bearing on the present cases.

C. The State's Interest in Preventing Coercion or Undue Influence Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

The State has a strong interest in preventing coercion or undue influence from being brought to bear on patients facing end-of-life decisions. Such pressure might come from health care providers seeking to redirect scarce medical resources and save on care costs or from family members who wish to spare themselves the emotional and financial drain of a loved one's protracted period of dying. These pressures justify state regulation to ensure that end-of-life decisions are made without coercion or undue influence.

Nevertheless, the risk of coercion is that a patient will be forced or pressured to choose a path that he or she would rather not choose. By seeking to enforce blanket prohibitions, petitioners would guarantee that in a large number of cases all choice is denied. Petitioners' proposed solution to the risk of coerced decisions -- removal of all decision making autonomy from the patient -- exacerbates the very problem it purports to solve.

The risks of coercion and undue influence are at least as great when a patient seeks to discontinue lifesaving medical care as when a patient seeks so-called *affirmative* aid. The same health professionals and family members face the same set of incentives when the patient's decision involves whether to discontinue medical treatment as they do when the patient's decision involves whether to seek a physician's aid in carrying out his or her decision to end life by other means.[12] Yet, as Petitioners concede, neither New

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[12] For example, the United States asserts that "[w]hen the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former." Brief for the United States as amicus curiae Supporting Petitioners at 24 (No. 96-110). Yet it is precisely such treatment that the United States and petitioners acknowledge that patients have a right to refuse, even when death will result. Similarly perplexing is the American Medical Association's concern that patients will seek aid in dying because they suffer from depression, *see* Brief of the American Medical Association, *et al.* at

York, Washington, nor any other State finds that these risks justify a ban on the discontinuation of lifesaving medical care, *see* Brief for the Petitioners at 12 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11 (No. 95-1858) -- nor could they so find, given this Court's understanding in *Cruzan* that the risks of error must be carefully balanced.

Indeed, many States, including New York and Washington, permit the appointment of a surrogate to make life and death treatment decisions in the event the patient becomes incapacitated. *See* N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993); Wash. Rev. Code Ann. § 11.94.010(3) (West Supp. 1996). When a patient has become incapacitated, the risk of a decision that reflects the interests of the surrogate or health care provider rather than the patient is at a maximum. In contrast, a mentally competent, terminally ill patient who seeks the assistance of a willing physician in carrying out his or her decision about how to live life's final days is in control of the decision making process in a way that cannot be true when a surrogate is required. By nonetheless allowing for surrogate decisionmaking in the event of incapacitation, the States recognize that the paramount interest in end-of-life decisions is ensuring that the patient's true wishes be carried out -- even when the risks of decisions based on other factors are substantially greater than when a mentally competent, terminally ill patient makes the ultimate decision.

Therefore, anecdotal evidence that permitting physicians to render aid in dying would lead doctors to pressure patients to end their lives, *see* Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure (1996), proves only that the States must have the authority to enact safeguards to ensure that a patient's decision is not the product of undue pressure. However, the state interest in preventing doctors from prescribing lethal medication to a patient who wishes to remain alive no more justifies a flat ban on such aid in dying than the identical state interest in preventing doctors from discontinuing lifesaving medical treatment against a patient's will would justify a blanket prohibition of patients' ability to discontinue such treatment.

In this context, regulation, as opposed to prohibition, is quite

8-9 (No. 95-1858), given that patients are equally likely to refuse, or seek the withdrawal of, lifesaving treatment because they suffer from depression.

practical. As the eponymous respondent in No. 95-1858, Dr. Timothy Quill, has himself noted, the patient's right to make unencumbered decisions to die with dignity can be insulated from coercive pressure by requiring multiple requests, a healthy doctor-patient relationship, secondary consultation with another physician and clear documentation of the decision process. *See* Quill, *Care of the Hopelessly Ill*, 327 New Eng. J. Med. 1380 (1992). In addition, palliative care groups could be required to review patient requests and physician decisions to minimize the risk of abuse while ensuring access to the procedure when it is medically and ethically justified. Such a review program is particularly well-equipped to counter the threat of coercion by family members, doctors, or health maintenance organizations, because palliative-care review focuses on the condition and desires of the patient. *See* Miller, *et al.*, *Regulating Physician Assisted Death*, 331 New. Eng. J. Med. 119 (1994). *See also* Appendix A.

Thus the concern of petitioners and their amici that patients will seek a physician's aid in dying without exploring palliative care options is misplaced.[13] If anything, recognition of the right asserted here will require States to adopt more precise regulatory mechanisms, with the likely result that many patients who legally seek aid in dying will be required to contemplate palliative care options that, under existing law, they would not have considered.

The State may enact a wide variety of reasonable measures designed to ensure that the patient's decision reflects his or her will, free of coercion or undue influence. What the State may not do is deny all patient choice in the name of safeguarding unfettered choice. Yet that is precisely what the New York and Washington laws do.

[13] In their focus on palliative care, petitioners and their amici obscure the fact that not all suffering experienced by terminally ill patients takes the form of physical pain. For many patients, the greater horror is the disintegration of their physical and mental capacities. To the extent that palliative care relies on sedation, it merely exacerbates the problem.

D. The State's Interest in Protecting the Handicapped and Other Disadvantaged Members of Society Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Opponents of the right claimed here assert that the State has an interest in avoiding measures that will have the cumulative impact of devaluing the lives of persons with disabilities. *See, e.g.,* Brief Amici Curiae of the National Legal Center for the Medically Dependent & Disabled, Inc. at 9-11; Brief Amicus Curiae of the Catholic Medical Association at 15-16. In its strongest form, the argument goes as follows: in order to avoid enshrining a general right to suicide, the State must designate some conditions as qualifying persons for a right to physician assistance in ending life; the State thereby impliedly asserts that the quality and value of life for persons in the designated conditions is lower than for other persons; to avoid sending this message of inferiority, the State should avoid drawing such lines.

Whatever the force of the above argument, it is simply irrelevant to the cases now before the Court. The patients here (and the doctors who wish to assist them) all suffer from terminal illnesses. As noted above, the distinction between such patients and persons who do not suffer from a terminal illness has nothing to do with an assessment by the State (or a court) of the value of life. The point is that with death inevitable and imminent, the State's general interest in preventing suicide -- the interest in protecting a future self against the possibly rash judgment of the present self -- is greatly diminished. The Court need not and should not say in these cases that the State has some obligation to allow physician-assisted suicide for persons with some set of disabilities but not for other persons. The Court can and should affirm the rulings below without in any way implying such an obligation.

To the extent that petitioners also assert that persons with handicaps and other disadvantages deserve protection from undue pressure, of course we agree. The State has a strong interest in ensuring that the vulnerable are not pressured to seek physician assistance in ending life, just as it has a strong interest in ensuring that the vulnerable are not denied equal access to the right asserted here. *See Compassion in Dying*, 79 F.3d at 825 (observing that the

poor and minorities are more often under pressure *not to* exercise their rights, as in the case of abortion). For this reason, we support efforts to enact legislation that would ensure that mentally competent, terminally ill patients who seek a physician's aid in dying are not acting in response to financial or other undue pressure. The same measures that would limit the opportunities for coercion in general will provide protection for persons who are members of disadvantaged groups. *See* Appendix A.

E. The State's Interest in Maintaining the Ethical Integrity of the Medical Profession Does Not Justify an Outright Ban on Physicians Rendering Assistance to Mentally Competent Terminally Ill Patients in Carrying out Decisions About how to Live Life's Final Days.

In order to protect constitutional rights, this Court has not hesitated to strike down legislation that reflects a professional organization's view of the limits of acceptable behavior. *See, e.g., Bates v. State Bar*, 433 U.S. 350 (1977) (invalidating ban on attorney advertising). *Cf. Florida Bar v. Went For It, Inc.*, 115 S. Ct. 2371 (1995) (applying commercial speech test to state bar regulations). Thus, although the American Medical Association officially disapproved of abortion as late as 1967, *see Roe*, 410 U.S. at 142-43 (citing Proceedings of the AMA House of Delegates 40-51 (June 1967)), the *Roe* Court nonetheless recognized such a right. The fact that some or many members of a profession deem a particular practice inconsistent with their professional role is a valid reason why no professional should be *forced* to engage in that practice. It is not a reason why a professional who is willing to depart from the official position should be *prohibited* from following his or her conscience.

Accordingly, the objection that state-sanctioned physician aid in dying would convert doctors from healers into killers has no greater purchase here than does the parallel argument in the abortion context. No doctor should be required to render aid in dying to a patient who seeks the doctor's assistance, just as no doctor is required by *Roe* and *Casey* to perform an abortion.

The question whether a particular practice such as aid in dying is inconsistent with a doctor's professional role cannot be answered, as petitioners and their amici suggest, by definitional fiat. Here, the

willingness of a professional to assist the individual will facilitate the exercise of constitutional liberty. Under these circumstances, a professional organization cannot declare, as *ipse dixit*, that such assistance contravenes the professional role, and ask the Court to defer blindly to its unilateral judgment.

In fact, despite laws like those challenged here, and despite the reflexive opposition of the American Medical Association, opinion polls consistently show substantial support among doctors for the provision of aid in dying to mentally competent, terminally ill patients.[14] These doctors evidently understand the practice as consistent with their professional role. They believe that to deny the only form of relief they can render their terminally ill patients is an act of cruelty.

The argument that permitting doctors to perform abortions would lead to a devaluation of human life by the medical community was rejected by the *Roe* Court. There is no empirical support for the predicted devaluation. Indeed, the very fact that the American Medical Association appears now before the Court, with its professional integrity intact after 23 years of legalized abortion, making the very same argument rejected in *Roe*, merely underscores the flaw in the argument. The Association was wrong in its pre-*Roe* position, and it is wrong now.[15] Individual doctors can be trusted,

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[14]Jerald Bachman found that 54% of physicians favored legislation legalizing physician assistance for terminally ill, mentally competent adults. Bachman, *Assisted Suicide and Active Euthanasia in Michigan*, 331 New Eng. J. Med. 812 (1994). Jonathan Cohen polled 938 doctors in Washington and found that 54% supported physician assistance under certain carefully limited circumstances. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994). A poll of 740 Wisconsin doctors showed 42% supported a right of physician assistance for competent adults faced with severe illness and little chance of recovery. 28% of the Wisconsin sample said they would be willing to perform the procedure, Shapiro, *Willingness to Perform Euthanasia*, 154 Archives Internal Med. 575 (Mar. 14, 1994) (WL, AMA-JNLS database) (1994).

[15] The Association is also wrong in its assertion that regulations of the sort currently under consideration by the state legislatures would work an "unprecedented intrusion into the physician-patient relationship" and "would be fundamentally inconsistent with the private nature of health care treatment." Brief of the American Medical Association, *et al* at 17 (No. 96-110). The rise of managed care has already transformed the physician-patient relationship from the model the Association portrays. *See* Shaw, Letter: *Economics and the Examination Room: An Incident*, 347 Lancet 124-25 (1996).

subject to careful but reasonable regulation, to prescribe lethal medication to mentally competent, terminally ill patients who need assistance in carrying out their decisions about how to live life's final days.

IV. Affirming the Judgments Below Would Give Proper Recognition to the Principle that this Court Shares Responsibility with the State and Federal Legislatures for Striking a Balance Between Constitutional Rights and Government Regulation.

Petitioners and their amici attempt to tantalize this Court with the fool's gold of a decision avoided. Their argument takes the form of the question-begging trope that the Constitution is silent on the issue posed by these cases. The argument is bad in itself. Of course the text of the Constitution does not expressly mention aid in dying, any more than it expressly refers to flag-burning, discrimination on the basis of skin color, or a host of other practices that fall within the Constitution's general language. *See McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819) (noting that the Constitution does not "partake of the prolixity of a legal code," and thus "only its great outlines should be marked").

Beyond its fundamental misapprehension of the nature of constitutional interpretation, the argument advanced by petitioners and their amici paints a vastly oversimplified picture of the reality the Court would face were it to reverse the judgments below. The Court would have to distinguish its commitment to even a very narrow version of the principle announced in *Cruzan*, namely that the Constitution affords protection to the right to refuse unwanted bodily intrusions, including means of respiration, nutrition and hydration. *See Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.").

To do otherwise, that is, to renounce the premise shared by eight Justices in *Cruzan* and expressly adopted by five Justices, would be to do irreparable harm to this Court's Due Process Liberty

jurisprudence. In *Casey*, this Court made clear that the right to choose an abortion free of undue government coercion encompasses the right to choose *not* to have an abortion free of government coercion. The Court stated that "*Roe* has been sensibly relied upon to counter any . . . suggestions" to the contrary. *Casey*, 505 U.S. at 859. In support of this proposition, the *Casey* Court cited a prominent decision of the New Jersey Supreme Court recognizing a right to refuse medical treatment. *See id.* (citing *In re Quinlan*, 70 N.J. 10, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)).

Therefore, in order to maintain even the semblance of principled adjudication, a decision reversing the judgments below would have to explain why a right to refuse medical treatment receives constitutional protection but a right to the assistance of a willing physician in hastening death by other means does not. The Court would then be faced with the daunting task of defining the limits of the right to refuse treatment.

Suppose, for example, that a State were to forbid the withdrawal of a feeding tube or respirator in cases in which the patient initially consented to its insertion. Such withdrawal is an active measure that brings about death. Could the State decide that it is therefore not encompassed within the right to refuse treatment, or would it be obligated to treat the continued operation of the feeding tube or respirator as an ongoing invasion?

If a physician prescribes a mentally competent, terminally ill patient a lethal dose of painkillers in violation of state law, may the State use force -- for example, could the State pump the patient's stomach -- to counteract the effect of the drug? *Cf. Rochin v. California*, 342 U.S. 165 (1952). In other words, is the State free to act to restore the status quo that existed prior to the illegal act, or must it ignore the antecedent violation and avoid what would now constitute a bodily invasion?

In the practice known as "terminal sedation," a physician prescribes a sufficient quantity of sedative to induce coma, but does not then treat the accompanying depression of respiration or inability to ingest; as a result, the patient dies by asphyxiation, starvation or dehydration. *See Terminal Sedation in the Care of Dying Patients*, Archives Internal Med. (Sep. 9, 1996) (WL, AMA-JNLS database). Is this practice encompassed within the rubric of the right to refuse medical treatment, as the American Medical

Association contends? Brief of the American Medical Association, *et al* at 12-13 (No. 96-110).

Should the Court reverse the judgments below, there will be no way to avoid answering questions such as these. When such questions reach this Court, commitment to principled interpretation will require that they be faced. There is simply no way around the hard truth that difficult lines must be drawn, *regardless of how the Court rules in these cases.*

Nevertheless, as we have argued above, the Court need not attempt to resolve all of the difficult constitutional questions presented by state regulation of end-of-life decisions. It is sufficient to note here that the blanket bans of New York and Washington go too far. A ruling to that effect would properly place the matter in the hands of the state legislatures.

Although we do not endorse all of Judge Calabresi's creative proposal in the court below, *see Quill*, 80 F.3d at 738-43 (Calabresi, J., concurring) (arguing that the court should provisionally invalidate New York's statute and remand to the legislature for a statement of present support), we agree with the fundamental insight underlying his approach: a proper understanding of American constitutionalism recognizes that the judiciary and elected representatives share responsibility for interpreting foundational norms. This Court, along with the lower federal courts and state courts, must not hesitate to declare invalid laws that go beyond the proper bounds of legislative authority. At the same time, however, there is a substantial gray area in which elected bodies should be permitted to pursue legitimate governmental objectives that touch upon the exercise of constitutional rights. *See Casey*, 505 U.S. at 873 ("not every law which makes a right more difficult to exercise is, ipso facto, an infringement of that right.")

There exists a significant variety of measures that would protect the State's legitimate interests without unduly burdening the ultimate decision of a mentally competent, terminally ill patient to seek a willing physician's aid in dying. Many of these measures have been proposed as bills in the legislatures of the several States. *See* Appendix A. A ruling by this Court affirming the judgment below would in no way impair this ongoing legislative process. Quite to the contrary, a properly narrow ruling would send the signal to the state legislatures that where constitutional liberty is concerned, they cannot paint with an extremely broad brush; nor can

they use talismanic categories as a substitute for reasoned judgment. As legislators with a sworn duty to uphold the Constitution and an obligation to protect the interests of all persons subject to our laws, we would welcome such a signal.

Conclusion

For the foregoing reasons, the judgments of the Courts of Appeals for the Second and Ninth Circuits should be affirmed.

Respectfully submitted,

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APPENDIX A

Recent Proposals and Enactments

This Appendix summarizes various proposals recently introduced for consideration in jurisdictions throughout the United States.

DEATH WITH DIGNITY PROPOSALS

At least eight States have considered adoption of similar legislation patterned after Oregon's "Death with Dignity Act," Or. Rev. Stat. §§ 127.800 *et seq* (1995). The current model state proposal differs in some respects from the Oregon statute, which is summarized separately below).

* **Status**: States in which the legislation has been proposed include the following:

- Arizona, S.B. 1007. Introduced January 8, 1996; to committee January 16, 1996.
- California, S.B. 1310 and A.B. 1080. Introduced February 23, 1995; died in committee, January 31, 1996.
- Colorado, H.B. 1185-96. Introduced January 1, 1996; referred to Committee; action postponed indefinitely, February 2, 1996.
- Maine, H.P. 552. Introduced March 7, 1995; House Committee on Judiciary votes not to recommend passage on June 14, 1995.
- Massachusetts, H.B. 3173. Introduced February 14, 1995.
- New Hampshire, H.B. 339. Introduced January 5, 1995; failed in House, January 4, 1996.
- Mississippi, H.B. 1023. Introduced January 22, 1996; died in committee February 6, 1996.
- Vermont, H.B. 335. Introduced February 21, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; set forth safeguards, procedures, immunities, and liabilities with respect to fulfilling such request; and make provision of aid in dying by hospital or physician voluntary. Would not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:
- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:
- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:
- Patient must make one written and two oral requests. Second oral request must be at least 15 days after written request. Physician must wait at least 48 hours after final oral request to write prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Requires two witnesses to patient's request; one witness shall not be related to or in a position to benefit from patient's death.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.
- Above information will not be available to public.
- State will conduct annual review of sample of records.

ADDITIONAL PROPOSALS AND ENACTMENTS

ALASKA -- H.B. 371:

* **Status**: Introduced January 8, 1996

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication, and authorize physician to prescribe lethal dose. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis.

Consideration of Alternatives:
- Primary physician must discuss feasible alternatives to aid in dying and offer alternatives immediately prior to issuing prescription.

Patient's Competence:
- Two physicians must determine that patient is mentally competent.

Voluntary and Informed Request:
- Patient must make one written and one oral request, with 10-day waiting period between requests.
- Following oral request, physician must confirm that patient has made an informed decision and offer patient the chance to revoke the request.
- Patient may revoke request at any time in any manner.
- Two witnesses must attest that patient has made voluntary and informed decision. Neither witness can: be related by blood; entitled to a portion of the patient's estate; have a creditor's claim against patient or estate; be the patient's physician or employed by the patient's health care provider.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be altered or made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

CALIFORNIA -- GUIDELINES OF THE BAY AREA NETWORK OF ETHICS COMMITTEES

* **Summary**: The Bay Area Network of Ethics Committees has prepared "Guidelines for Comprehensive Care of the Terminally Ill," including provisions on aiding terminally ill patients to hasten their death. The guidelines acknowledge the difficulty in treating patients facing protracted, painful terminal illness and difficult decisions regarding end-of-life care. The guidelines urge primary care physicians to consider referrals to appropriate hospice programs and/or consultation with physicians experienced in palliative care. When the patient has requested a physician's aid in dying, the group recommends extensive safeguards and quality-of-care guidelines, summarized below.

* **Safeguards**:

Diagnosis
- Physician should obtain second opinion on terminal diagnosis.

Mental Competence
- Physician should confirm that patient is competent and obtain a second opinion as to competence.
- Physicians are urged to seek appropriate aid from other practitioners in medical and mental health communities.

Consideration of Alternatives
- Physician should ensure that patient has access to palliative care.
- Documentation of patient's evaluation by hospice program or palliative care specialist, or of patient's decision to decline such care.

Voluntary and Informed Decision
- Physician should urge patient, where appropriate, to consult family members and other affected parties in making end-of-life decisions.
- Patient should sign two witnessed statements that decision is voluntary and informed. The second should be executed at least 48 hours after the first. Both should be signed before two witnesses who are unrelated to patient and in no position to benefit from patient's death.

- Physician should ensure that patient is aware that request is revocable at any time.

Documentation
- Before writing prescription, physician should confirm that all of the above have been duly documented.

MARYLAND -- H.B. 474

* **Status**: Introduced January 31, 1996.

* **Summary**: Would, *inter alia*, allow a mentally competent adult suffering from painful terminal condition to request aid in dying, set forth procedures and safeguards for carrying out such request, and make participation in aid in dying optional for physicians and hospitals.

* **Safeguards**:

Confirmation of Diagnosis:
- Diagnosis of painful fatal condition by two physicians; physicians may not be partners or shareholders in the same medical practice (except as members of the same HMO).

Consideration of Alternatives:
- Physician must determine that passive withdrawal of life-sustaining medical support or withholding of nutrition and hydration will not alleviate suffering.

Patient's Competence:
- Physician must determine that patient request is not the result of clinical depression.
- Physician may refer patient to counseling if appropriate.

Voluntary and Informed Decision:
- Patient must make three requests, including one written request.
- Requires waiting period of two weeks between first and final requests.
- Request is revocable at any time without regard to mental capacity.

Authenticity of Request:
- Two witnesses to written request must attest that patient appears to be competent and acting voluntarily.

Prevention of Coercion:
- Insurance benefits and health care services may not be made contingent on execution of execute aid-in-dying request.
- Misdemeanor penalties for persons who forge, alter, conceal, or procure through undue influence or coercion an aid in dying

request or revocation of such request.

MICHIGAN -- H.B. 4134:

* **Status**: Introduced, January 17, 1996.

* **Summary**: Would allow qualified patients to make revocable request for aid in dying, defined here as "provision of a lethal agent;" create judicial review of aid-in-dying requests and revocations; create immunities for those who provide aid-in-dying.

* **Safeguards**:

Diagnosis:

- Two physicians must confirm diagnosis.

Consideration of Alternatives:

- Two physicians and one qualified mental health counselor must discuss treatment options with patient.

Patient's Competence:

- Primary physician and psychologist or other physician must determine mental competence.

Voluntary and Informed Decision:

- Qualified counselor must discuss with patient motivations for aid-in-dying request. Three-day waiting period between counseling and provision of aid in dying.
- Written and oral request required, with 15-day waiting period between requests.
- Patient may revoke request at any time and in any manner.

Prevention of Coercion:

- Declares void any contract provision, including insurance plans and wills, that are contingent on execution of aid-in-dying requests; prohibits insurers from refusing coverage, altering policy terms or invoking exemptions on the basis of aid-in-dying requests.
- Felony punishment for forgery, fraudulent inducement or coercion with respect to aid in dying request, or concealment or destruction of revocation of such request, resulting in death.

Additional Safeguards:

- Creates cause of action for specified relatives to clarify status of patient's request, and requires expedited consideration of such actions;
- Allows health facilities to create additional safeguards, and makes provision of aid in dying by health facilities and physicians voluntary.

NEW YORK -- S.B. 5024; [S.B. 1683; A.B. 6333]

* **Status**:

- S.B. 5024: Introduced on May 3, 1995; in Senate Committee on Health as of 1/3/96.
- S.B. 1683: Introduced February 1, 1995.
- A.B. 6333: Introduced on April 22, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; establish safeguards and record-keeping procedures for fulfilling aid-in-dying requests; and make provision of aid in dying by hospital or physician voluntary. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:

- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:

- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:

- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to issue prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Two witnesses, one of whom shall not be related to or in a position to benefit from patient's death, must confirm that patient appears to be competent and acting voluntarily.

Prevention of Coercion:

- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.

- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

OREGON -- Or. Rev. Stat. §§ 127.800 *et seq.* (1995)

* **Summary**: Allows competent adult diagnosed with terminal illness to make voluntary, informed request for medication to end his or her life; specifies the form of written request; and sets forth safeguards, procedures, immunities, and liabilities with respect to honoring such request; administration of request for lethal medication is voluntary for health care providers and organizations.

* **Safeguards**:

Diagnosis:

- Diagnosis of terminal illness must be made by two physicians.

Consideration of Alternatives:

- Attending physician must discuss feasible alternatives, including comfort care and pain control, with patient.

Patient Competence:

- Determination of mental competence must be made by two physicians;
- Attending and consulting physician each under duty to refer patient to counseling if deemed necessary.

Voluntary Decision:

- Physicians must confirm that patient's decision is voluntary when making diagnosis and immediately prior to issuing prescription.
- Two witnesses, one of whom may not be related to patient by blood, entitled to a portion of patient's estate, or an owner or employee of facility treating patient, must attest that patient is acting voluntarily.
- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to

issue prescription.

- Patient may rescind request at any time and in any manner, without regard to mental state.
- Physician must offer patient opportunity to rescind request before writing prescription.

Coercion

- Provisions in contracts or wills that would affect a person's decision whether to make or rescind a request under this statute are invalid.
- No contractual obligations, insurance or annuity policies can be conditioned or affected by making or rescission of request.
- Forgery or alteration of request for medication, and concealment or destruction of rescission of such request, with intent or effect of causing death, is a felony.
- Coercion or undue influence with respect to request or rescission, with intent or effect of causing death, is a felony.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

RHODE ISLAND -- S. 2985.

* **Status**: Introduced February 6, 1996.

* **Summary**: Would authorize physicians to help competent adults suffering from terminal or intractable and unbearable illness to obtain the medical means of suicide, and to assist patient in administration of such means.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives

- Physician must offer alternative treatments, including palliative or hospice care, as well as counseling, and must discuss thoroughly diagnosis and prognosis.

Patient's Competence:

- Written opinion from qualified mental health professional as to patient's competence.

Voluntary and Informed Decision
- Requires two requests by patient, at least 14 days apart; second request must be no more than 72 hours before physician provides patient with medical means of dying.
- Consulting physician and mental health professional must confirm in writing that patient is acting voluntarily.
- Witness must confirm that physician has presented patient with information concerning treatment options and that patient is acting voluntarily.

Prevention of Coercion
- Prohibits insurers, health plans and providers from making services or benefits contingent on request for physician-assisted suicide. Patient's use of aid in dying will not be deemed suicide for insurance purposes.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

WASHINGTON -- S.B. 5596

* **Status**: Introduced January 27, 1995.
* **Description**: Would allow a competent, terminally ill adult to make a voluntary, revocable request for physician to prescribe lethal dose of medication to be self-administered by patient; authorize health care providers to participate in aid-in-dying requests.
* **Safeguards**:

Diagnosis:
- Two physicians must independently agree on diagnosis.

Consideration of Alternatives
- Both primary and consulting physician must discuss with patient feasible alternatives to aid in dying.
- Immediately prior to issuing prescription, physician must confirm that patient has been offered all treatment alternatives.

Patient Competence
- Consulting physician to make independent determination of competence

Voluntary and Informed Decision
- Request must be made in writing or on videotape in the presence of two witnesses, neither of whom is related to patient or stands to benefit from patient's death.
- Request for aid in dying may be revoked at any time through

various means.
- Insurance and health plan coverage, benefits and treatment cannot be made contingent upon request for aid in dying.
- Undue influence upon patient to request aid in dying, including through persuasion that patient is financial or emotional burden, punishable as misdemeanor or, if death results, as felony.
- Fraud, forgery, or falsification as to aid in dying request, and concealment or destruction of revocation of such request, punishable as misdemeanor or, if death results, as felony.

WISCONSIN -- A.B. 174, S.B. 90

* **Status**: Introduced April 2, 1995.
* **Summary**: Permits competent adults suffering from terminal illness to make voluntary request for medication to end life.
* **Safeguards**:

Diagnosis:
- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives:
- Physician must inform patient of feasible alternatives.

Patient's Competence
- Physician must refer patient for counseling if deemed appropriate by either primary or consulting physician.

Voluntary Nature of Request
- Patient must make three requests: an oral request, followed at least 15 days later by a written request, followed by a second oral request. At least 48 hours must elapse between final request and issuance of prescription.
- Patient may revoke request at any time in any of several specified ways.
- Three witnesses, none related by blood, entitled to a portion of patient's estate, or financially responsible for patient's health care.

Prevention of Coercion
- Criminal penalties for forgery or falsification of aid-in-dying request, or concealment of knowledge of rescission of such request.
- Patient may not be required to make an aid-in-dying request as a condition for receipt of health care.

Recording Requirements
- Patient's medical file must include documentation of: all oral

and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

APPENDIX B

List of *Amici*

Name	State
Representative Kay Brown	Alaska
Representative John Davies	Alaska
Senator Johnny Ellis	Alaska
Representative David Finkelstein	Alaska
Representative Cynthia Toohey	Alaska
Senator Peter Goudinoff	Arizona
Representative Peggy Lamm	Colorado
Senator George Jepsen	Connecticut
Representative Mike Lawlor	Connecticut
Senator Edith Prague	Connecticut
Representative Wendy Jaquet	Idaho
Representative Sara Feigenholtz	Illinois
Representative Barbara Flynn Currie	Illinois
Representative Fred Richardson	Maine
Representative Barbara Dobb	Michigan
Representative Jan Dolan	Michigan
Representative Susan Grimes-Munsell	Michigan

Senator Ernie Chambers	Nebraska
Senator Liz Stefanics	New Mexico
Senator Franz Leichter	New York
Senator Ron C. Cease	Oregon
Representative Edith Ajello	Rhode Island
Representative David Cicilline	Rhode Island
Senator Rhoda Perry	Rhode Island
Senator John Roney	Rhode Island
Senator Charles Walton	Rhode Island
Representative Alan Bjerke	Vermont
Representative Lynn Bohi	Vermont
Representative Dean Corren	Vermont
Senator Jeanne Kohl	Washington
Representative Ed Murray	Washington
Representative Helen Sommers	Washington
Senator Pat Thibaudeau	Washington
Representative Georgette Valle	Washington
Representative Tammy Baldwin	Wisconsin
Senator Fred Risser	Wisconsin

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Nos. 95-1858 and 96-110

Supreme Court, U.S.
FILED
DEC 10 1996
CLERK

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF AMICI CURIAE SUPPORTING RESPONDENTS OF THE AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF WASHINGTON, NATIONAL GRAY PANTHERS PROJECT FUND, (continued on back of cover)

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INTERESTS OF AMICI CURIAE

The interests of amici curiae are set forth in the appendix to this brief.[1]

SUMMARY OF ARGUMENT

At issue in this case is no more and no less than (1) whether a mentally competent, terminally ill person suffering intolerably has a liberty interest protected by the Fourteenth Amendment in choosing to hasten the timing of an inevitable death, (2) whether a state's interests can justify a blanket prohibition on physicians providing assistance in the exercise of such a liberty interest, if it so exists, and (3) whether a state can justifiably grant certain persons the opportunity to make the choice to hasten death while denying to other, similarly situated persons the same opportunity.

The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. The exercise of this right is as central to personal autonomy and bodily integrity as the exercise of rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by hastening his or her own death.

A state's categorical ban on physician assistance to suicide — as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death — substantially interferes with this protected liberty interest and cannot be sustained. Though a state has significant interests in ensuring that the right at issue here is not abused or misused, an absolute ban on physician assistance unduly burdens the proper exercise of the right of the terminally ill to seek freedom from pain through death,especially given the less restrictive alternatives that are

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[1] Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

available to a state and that would in fact greater serve its claimed interests.

Indeed, states typically and successfully employ less restrictive alternatives than blanket prohibitions for terminally ill patients depending on life-sustaining treatment who wish to hasten death. States have recognized the right of this class of terminally ill patients to escape pain and hasten death through the termination or refusal of such life support and accompanying administration of large and lethal doses of pain-suppressing medication. Accordingly, a state denies equal protection of its laws when it provides that one class of persons may exercise this right while others who are similarly situated for all relevant purposes are wholly denied the opportunity to exercise the same right for the same reason.

ARGUMENT

I.

THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS THE PERSONAL CHOICE OF A MENTALLY COMPETENT, TERMINALLY ILL INDIVIDUAL TO END UNENDURABLE SUFFERING AND HASTEN INEVITABLE DEATH

The Due Process Clause of the Fourteenth Amendment declares that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has long been held to contain a substantive component forbidding certain government actions regardless of procedural fairness. See *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 846 (1992); *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986).

The content of substantive due process — *i.e.*, the constitutionally protected interests comprehended within the term "liberty" — cannot be determined by easy reference to any rule, text or historical period. "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Casey*, 505 U.S. at 848. In the words of Justice Harlan,

> the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution.... It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints.

Poe v. *Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting). Accordingly, in determining the reach of the "least specific and most comprehensive protection" that is the Fourteenth Amendment's guarantee of liberty, courts must employ considered reason and remain "duly mindful of reconciling the needs both of continuity and of change in a progressive society." *Rochin* v. *California*, 342 U.S. 165, 170, 172 (1952); see also *Casey*, 505 U.S. at 847-49 (courts must employ "reasoned judgment" to determine the scope of that "realm of personal liberty which the government may not enter").

Although the boundaries of substantive due process "are not susceptible of expression as a simple rule," *Casey*, 505 U.S. at 849, this Court has articulated two basic lines of inquiry for deciding whether a particular right falls within the liberty provision of the Due Process Clause. First, the Court has looked to whether the asserted right is "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977). Second, the Court has consulted the present conscience of the people to determine whether the asserted right is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed." *Palko* v. *Connecticut*, 302 U.S. 319, 325-26 (1937).

In this case, either line of inquiry leads to the conclusion that a mentally competent, terminally ill person's decision to escape unendurable suffering by choosing to die is entitled to recognition as a constitutionally protected liberty interest. That is, the right of the terminally ill to find relief from excruciating pain by hastening death bears the sanction of history. It is also entirely consistent with other rights of fundamental personal autonomy that this Court has found "implicit in the concept of ordered liberty" and thus embraced by the Fourteenth Amendment's Due Process Clause.

A. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Deeply Rooted in this Nation's History and Tradition.

Petitioners and their supporting amici contend that history and tradition support their position, but in doing so they improperly define the practice at issue here. Although history's view of suicide generally is subject to debate, this case presents only the narrow question of whether a mentally competent, terminally ill person has a right to seek an end to intolerable suffering by hastening an inevitable death.[2] Framed in these terms, the historical analysis appears very different. In fact, there is a strong historical tradition accepting, and often honoring, terminally ill persons who choose a timely and dignified death in the face of unrelenting and unendurable suffering.

This tradition traces back at least as far as the Greek and Roman philosophers, who accepted suicide where necessary to achieve a dignified death and to escape from a terminal and incapacitating disease.[3] For example, Plato's *Republic* sanctioned a choice to die under such circumstances: "If any man labour of an

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[2] The complaint in the case from Washington asserted the issue in terms of whether the "Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. The first paragraph of the complaint describing the nature of the action brought in New York asserted the issue in the same terms.

As the Ninth Circuit noted, following the approach of this Court's abortion decisions, the liberty interest at stake is not the right to *assistance* with suicide but, rather, the right of the terminally ill to hasten their death. If such a right exists, then the inquiry is whether a complete ban on assistance in exercising this liberty interest constitutes an undue burden. See *Compassion In Dying* v. *Washington*, 79 F.3d 790, 801-02 (9th Cir. 1996).

[3] This Court has considered the moral tradition of the Greeks in assessing other liberty interests. See *Roe* v. *Wade*, 410 U.S. 113, 130-32 (1973).

incurable disease, he may dispatch himself, if it be to his good."[4] Similarly, the Stoics of Rome, who believed that freedom must be based on the dictates of the deliberative will rather than passion or compulsion, embraced suicide as an appropriate response to a terminal illness whose overpowering physical assaults and demands would otherwise superimpose itself on the will and usurp the freedom of the sufferer.[5]

Significantly, neither the Old nor the New Testament prohibits suicide.[6] The notion of suicide as a crime was not introduced until late in Christian doctrine, and then only as a response to the temptation that martyrdom held for the early Christians.[7] Moreover,

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[4] *The Republic of Plato* Book III, 406a-409 (Alan Bloom ed. 1968). Aristotle, too, endorsed this possibility in his *Politics*. See *Aristotle's Politics* III, vi, 1278b15-30

[5] See Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 441-42 (1992). Writing in this tradition, Seneca, the great Roman orator, stated:

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leaves my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.

Quoted in Sherman B. Nuland, *How We Die* 151 (1993).

[6] None of the four suicides recorded in the Old Testament — Samson, Saul, Abimelech and Achitophel — is criticized. See Alfred Alvarez, "The Background" 12, *in* M. Babst Battin & David J. Mayo, *Suicide: The Philosophical Issues* (1980). The New Testament (Matthew) records the suicide of Judas Iscariot perfunctorily, "instead of being added to his crimes, it seems a measure of his repentance." *Id.* "In the first years of the Church, suicide was such a neutral subject that even the death of Jesus was regarded by Tertullian, one of the most fiery of the early Fathers, as a kind of suicide." *Id.*

[7] The Christian church taught that the world was a vale of tears, sin and temptation, from which death would release the faithful into eternal glory. Martyrdom afforded certain redemption, and the names of early martyrs were celebrated and their relics worshiped. The temptation to martyrdom culminated in the frenzy of the Donatists who, in the fourth and fifth centuries, actively pursued death. In response, St. Augustine argued in his writings that suicide was a sin.

despite the Church's general prohibition on suicide, certain prominent adherents recognized the appropriateness of choosing death as a means to end intolerable suffering for the terminally ill. Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of those with incurable diseases to commit suicide, and in *Utopia* he depicted the ideal treatment of the terminally ill, "full of continual pain and anguish," as allowing the patient to "despatch himself out of that painful life, as out of a prison."[8]

The origin of suicide as an English common law offense was also ecclesiastical; thus, the initial penalty was merely the denial of a Christian burial.[9] During feudal times, the penalty was expanded to include the forfeiture of goods to the suicide's liege lord; later, the Crown declared suicide a felony, primarily because a felon's goods were then forfeited directly to the King.[10] The common law, however, has never treated all suicides alike. Of greatest significance here, it was more lenient from the outset with those who killed themselves due to an inability to endure the suffering of disease.[11]

The crime of suicide, along with the rest of English common law, migrated to the American colonies, but it never took root even in its more limited form. As the Ninth Circuit explained: "There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the

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These arguments, coupled with the example of the Donatists, convinced the Church to legislate against suicide. See *id.* at 25-28.

[8] Quoted in O.R. Russell, *Freedom to Die* 55-56 (1975).

[9] See Maria T. CeloCruz, Note, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 373 (1992).

[10] *Id.* at 373-74.

[11] See *Compassion*, 79 F.3d at 808-09 (citing 2 H. de Bracton (c. 1250) reprinted in *On the Laws and Customs of England* 423 (S. Thorne trans., 1968)).

37 states is it clear that there were statutes prohibiting assisting suicide." *Compassion In Dying* v. *Washington*, 79 F.3d 790, 809 (9th Cir. 1996).

Today, no American jurisdiction criminalizes suicide or attempted suicide. And while a small majority of states currently criminalize assistance to suicide, there is no reported American case of a physician criminally punished for helping a patient commit suicide notwithstanding the fact that assisting the terminally ill who wish to hasten their deaths has been a time-honored, though hidden, practice of compassionate physicians.[12] For well over the past half century, no person (physician or otherwise) has been meaningfully punished for aiding the terminally ill to end their suffering.[13] This reluctance to prosecute and failure to punish can only be explained by society's abiding judgment that it has no right to insist on the continued suffering of the terminally ill, and no right to punish those who honor the request of the terminally ill by assisting them in ending their agony.[14]

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[12] See *id.* at 811 & nn.56-59; see also Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2021 n.7 (1992).

[13] "[F]rom 1930 to 1985, not one state court decision on an actual prosecution for suicide assistance appears in an official state reporter." Catherine D. Shaffer, Note, *Criminal Liability for Assisted Suicide*, 86 Colum. L. Rev. 348, 358 (1986). Based on newspaper and wire service accounts, it appears that such cases either have not been prosecuted or have resulted in acquittal or sentences of probation. See *id.* In the last decade, of course, there have been several well-publicized prosecutions. All, so far, have resulted in jury acquittals. See Jeff Stryker, *A Bedside Manner for Death and Dying*, N.Y. Times, May 19, 1996, § 4, at 3.

[14] Indeed, to argue that suicide by persons suffering from terminal illness is ethically wrong, philosophers and theologians have had to resort to the concept of God's proprietary claim over his creations. John Locke argued that suicide was a crime because man does not have absolute dominion over himself; his being belongs to God and he thus has no right to destroy it. "[M]en being the workmanship of one omnipotent ... makes all servants of one sovereign master, sent into the world by his order and about his business — they are his property, whose workmanship they are, made to last during his, not another's pleasure." John Locke, *The Second Treatise of Government* 9, 17, 21 (C.B. Macpherson ed. 1980). The theologian, Dietrich Bonhoeffer, has similarly stated: "It becomes quite clear that a purely moral judgment on suicide is impossible, and indeed that suicide has nothing to fear from an atheistic ethic. The right to suicide is nullified

There is nothing new about the desire of terminally ill patients to end their suffering by hastening death. Developments in modern health care have simply brought into the open a previously private practice that society has long condoned. Until the early part of this century, patients suffering from incurable conditions overwhelmingly died at home due to the limitations of the health care system. Their deaths were frequently eased by the ministrations of alcohol and opiates.[15] Indeed, opiates (including morphine), which lead to death in excessive doses, were available without prescription until 1914. Thus, terminally ill patients had at their disposal throughout the Nation's early history the means of hastening death in a certain and gentle manner when their pain became unendurable.

With the regulation of morphine and other opiates during the last century, this gentle quitting of a life ravaged by terminal disease became dependent on the aid of compassionate physicians. The evidence shows that, despite the strictures of the criminal law, many physicians have long been willing to provide such assistance.[16] They do so in response to an undeniable reality. More recent advances in medicine, which have dramatically increased the life span of the terminally ill, have also stretched out the "death span," prolonging the agony of the end stages of terminal disease,

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only by the living God." Quoted in P. Baelz, "Suicide: Some Theological Reflections," *in* Battin & Mayo, *supra*, at 75.

However deeply held such religious views may be, they cannot (without more) be the basis for government regulation. See *Casey*, 505 U.S. at 850 (explaining that particular spiritual or moral views concerning a liberty "cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."); *id.* at 914 (Stevens, J., concurring in part and dissenting in part) ("[I]n order to be legitimate, the State's interest must be secular; consistent with the First Amendment the State may not promote a theological or sectarian interest.").

[15] *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 339 n.11 (1990) (Stevens, J., dissenting).

[16] See generally Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1290, 1297-99 (1993); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 694 (1991).

often accompanied by severe pain, physical deterioration, and unspeakable indignities.

In sum, a review of this nation's history and tradition in fact provides considerable support for recognition of a constitutionally protected liberty interest in the choice of the terminally ill to bring an end to their suffering by hastening an inevitable death.

B. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Implicit in the Concept of Ordered Liberty.

The right of the terminally ill to hasten their death and escape intolerable pain is not only grounded in history, it is also implicit in the very concept of ordered liberty, as this Court has understood and applied that notion in past decisions. In particular, the combined force of *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), leads to the conclusion that the right of the terminally ill to quit a life burdened by intractable pain in a gentle and dignified manner is at the core of the liberty interests protected by the Constitution.

Cruzan and *Casey* do not stand alone, however. They represent only the latest examples of an enduring principle that has found expression in numerous cases over the years. This Court has repeatedly protected from state intrusion a set of decisions that go to the very essence of what it means to be an individual in command of a personal history and life course — decisions relating to marriage, family relationships, conception, procreation, child rearing, education, and the refusal or termination of life-saving medical treatment. See *Casey*, 505 U.S. at 849 ("It is settled now...that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.") (citations omitted). Review of this well-settled line of cases reveals the vital presence of three distinct, though interrelated, components of "liberty," each of which strongly supports a finding of constitutional protection for the right of the terminally ill to hasten inevitable death.

The first and perhaps pre-eminent component of "liberty" protects the individual's interest in personal dignity and decisional autonomy. See *Moore* v. *City of East Cleveland*, 431 U.S. 494 (1977); *Roe* v *Wade*, 410 U.S. 113 (1973); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Loving* v. *Virginia*, 388 U.S. 1 (1967); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Prince* v. *Massachusetts*, 321 U.S. 158 (1944). These cases develop the central notion that liberty only has meaning if an individual is able to make central decisions concerning his or her own life free from significant governmental interference. The decision in *Casey* stands as the most recent and most cogent articulation of these principles:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

505 U.S. at 851.

It is beyond dispute that the decision to control the end of one's life when confronted with terminal illness and intolerable pain is among the most critical and personal decisions an individual can make. Indeed, given its profound significance to a person's individual, familial, moral, spiritual and religious beliefs, it is difficult to view any other life choice as striking more to the core of personal dignity and autonomy than the decision of a competent and suffering terminally ill patient concerning how and when to die. Both the majority and dissents in *Cruzan* stressed the fundamental nature of the choice at issue here. See *Cruzan*, 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality."); *id.* at 310-11 (Brennan, J., dissenting) ("Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."); *id.* at 343 (Stevens, J., dissenting) ("Choices about death touch the core of liberty. Our duty, and the concomitant

freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'... [N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.") (citations omitted).

The second component of "liberty" to be found in this Court's cases involves bodily integrity. The line of cases supporting this component arose primarily in the context of medical procedures, and a person's right to direct the course of his or her own treatment. See *Washington* v. *Harper*, 494 U.S. 210 (1990); *Winston* v. *Lee*, 470 U.S. 753 (1985); *Schmerber* v. *California*, 384 U.S. 757 (1966); *Rochin* v. *California*, 342 U.S. 165 (1952); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). Here the *Cruzan* decision makes the latest and most germane statement about the role of bodily integrity in liberty. The majority in *Cruzan* explained that this Court's precedents indicate that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," 497 U.S. at 278, and Justice O'Connor in concurrence stressed that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination ...." 497 U.S. at 287 (O'Connor, J., concurring).

Cruzan stands for the proposition that the bodily integrity component of liberty, which encompasses the right to direct one's own medical treatment, is so fundamental that it is to be honored even when the consequence of the choice is hastening an individual's death. Accordingly, this component of liberty must extend to persons like the patient-plaintiffs who, with their lives ending and their bodies wracked with pain, sought the means to preserve their dignity and control over their bodily integrity by obtaining prescribed medication to terminate their suffering.[17]

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[17] Though the United States finds that "*Cruzan* supports the conclusion that a liberty interest is at stake in this case," Govt. Br. in *Glucksberg* at 15, it also suggests that this case does not involve *Cruzan*'s interest in "avoiding invasions of bodily integrity." *Id.* at 16. Such a view misses the reality of those who seek to exercise the right at issue here. Like the patient-plaintiffs in these cases, dying patients seeking to hasten death are typically in excruciating pain and often

The third and final component of "liberty" supporting the constitutional right of terminally ill patients to choose a peaceful death is the right to avoid intolerable suffering. As the United States highlights, see Govt. Br. in *Glucksberg* at 14, a liberty interest is surely implicated if the State itself inflicts severe pain and suffering. See *Ingraham* v. *Wright*, 430 U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when the state interferes with an individual's ability to relieve his or her pain, as the United States again appropriately recognizes. See Govt. Br. in *Glucksberg* at 14-15; cf. *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976). *Casey* acknowledges that the ability to seek relief from pain is a component of the "liberty" protected under the Due Process Clause — especially when the pain at issue is itself integrally bound up with a decision which implicates the dignity and autonomy interests in directing one's own life course that are also the province of the Due Process Clause:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.... Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role.... The destiny of the woman must be shaped to a large

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physically incapacitated; frequently their entire bodily existence is conscripted by the demands and relentless assaults of an incurable disease. To suggest that such persons' "bodily integrity" is unaffected if they are denied the opportunity to seek medication to bring their suffering to an end — and are thereby forced to continue an existence which they view as a torment — evinces a remarkably hollow conception of the right to bodily integrity. Of course, this Court's precedents encompass a much fuller conception of bodily integrity. As *Casey* made clear when it held that denial of access to the medical procedure of abortion touches "upon the very bodily integrity of the pregnant woman," 505 U.S. at 896, this Court has recognized an interference with a liberty interest whenever persons have particular courses of medical treatment thrust upon them or denied to them contrary to their interests or consent. See, *e.g.*, *Washington*, 494 U.S. at 229; *Jacobson*, 197 U.S. at 24-30; see also *Vitek* v. *Jones*, 445 U.S. 480, 494 (1980); *Parham* v. *J.R.*, 442 U.S. 584, 600 (1979).

> extent on her own conception of her spiritual imperatives and her place in society.

505 U.S. at 852.

The same principle applies where a state prohibition relegates competent, terminally ill individuals to continue to suffer acute pain without the option of a gentle, hastened death. Like the pregnant woman's decision, the decision of a terminally ill individual to quit life in the face of unendurable pain and certain death is too intimate, too personal, and too central to the totality and meaning of that person's life for the State to impose its own philosophical and moral imperatives upon that decision. Indeed, the personal stories of the patient-plaintiffs plainly illustrate the extent of the suffering at stake in these cases.[18] The United States properly recognizes this "significant liberty interest" in its brief, noting that "it persists even at the point at which avoiding severe pain and suffering coalesces with ending life." Govt. Br. in *Glucksberg* at 16. This view resonates fully with the decision in *Cruzan*, which

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[18] Washington notes that respondents and their supporting amici placed before the Courts of Appeals numerous "anecdotes" of the terminally ill who wished to hasten their death and avoid painful, undignified and inhumane endings to their lives. The State of Washington urges that this Court not make constitutional decisions based on "anecdotes." See Washington Br. at 18. But these personal stories, though brief and obviously inadequate to portray essentially indescribable human suffering, are meant to help the Court to conjure the unimaginable pain and suffering experienced by those who might avail themselves of the right urged here. As the United States acknowledges, see Govt. Br. in *Glucksberg* at 18 & n.1, an irreducible core of terminally ill patients (including an estimated 10% of all cancer patients) cannot obtain relief through palliative treatment but are trapped in physical agony. In some cases, pain cannot be controlled even with full and appropriately timed doses of narcotics; in other cases, the toxic effects of the palliative agents may be intolerable. See Howard Brody, *Assisted Death — A Compassionate Response to Medical Failure*, 327 New Eng. J. Med. 1385 (1992). Moreover, the invocation of the capabilities of modern palliative medicine ignores the subjective nature of suffering; the diminished fortitude in the face of suffering when all hope of recovery is gone; the practical reality that pain can often only be allayed, if at all, at the cost of mental alertness; and the loss of dignity that accompanies physical deterioration. In these circumstances (the "anecdotes" that respondents and their amici place before the Court), compassion and the Constitution dictate that these terminally ill patients not be denied their wish for a hastened and gentle death.

teaches that a liberty interest persists even to the point where an individual decides to hasten his or her death through the refusal of life-sustaining treatment.[19]

These three components of "liberty," all recognized by this Court as hallmarks of "the concept of ordered liberty," forge a strong base of constitutional support protecting the right of a competent, terminally ill person to choose to end suffering by gently hastening death. To deny constitutional protection for this right would undermine concepts of liberty and autonomy previously recognized as sacrosanct. "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[20] The right to define the limits of one's endurance in the face of terminal illness and to embrace a swifter, more gentle death, should be recognized as an essential component of liberty under the Due Process Clause.

II.

A BLANKET PROHIBITION AGAINST AID TO SUICIDE UNDULY BURDENS THE RIGHT OF THE TERMINALLY ILL TO MAKE RATIONAL END OF LIFE DECISIONS

If this Court determines that the right of the terminally ill to escape intolerable pain and suffering through hastening death is a liberty interest protected by the Fourteenth Amendment, there can be little doubt that the laws at issue here "operate as a substantial obstacle" to the exercise of that constitutionally protected personal liberty interest. *Casey*, 505 U.S. at 895.

Amici acknowledge that the states have a significant interest in the preservation of life that permits them to regulate, even quite extensively, the exercise of the right of the terminally ill to choose

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[19] In *Cruzan*, this Court noted that the "logic of [prior] cases" would extend the liberty interest in refusing medical treatment to refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279.

[20] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* 217 (1993).

the time and manner of their death. Indeed, such regulation is undoubtedly appropriate to ensure that the right at issue here is not misused. This case, however, does not involve regulation, but prohibition. And, in this context, it is undeniable that an *absolute* ban on obtaining assistance from a physician unduly burdens the right of the terminally ill to escape pain by hastening death. Indeed, for many terminally ill patients, it precludes it entirely. Furthermore, there are less restrictive alternatives available that would in fact better serve the interests claimed by the states in this case.[21]

A. A Blanket Ban on Assistance to Suicide Is a Substantial Obstacle to the Right of the Terminally Ill to End Their Suffering.

A state's blanket prohibition against aid in dying unduly burdens the right of terminally ill individuals to end their suffering and hasten their death, preventing significant numbers of terminally ill from achieving the release from suffering that they desire and relegating still others to unacceptable options. Along with improving and extending life, the advances of modern medicine have transformed radically the social circumstances of death. Whereas only a generation ago the vast majority of persons died at home, now approximately 80% of individuals die in hospitals and long-term care institutions.[22] It is, as a practical matter, impossible for

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[21] This Court has not always employed a single test when weighing the strength of the state's asserted justification for abridging a fundamental liberty interest. In *Casey*, the Court adopted an "undue burden" test that focussed on whether the challenged regulation placed a "substantial obstacle" in the path of a woman seeking a pre-viability abortion. In other contexts, this Court has emphasized the need for narrow tailoring. See, *e.g.*, *City of East Cleveland*, 431 U.S. at 499. Under either formulation, a total ban on physician-assisted suicide cannot be upheld. As explained below, it clearly represents a "substantial obstacle" to terminally ill individuals who wish to end their suffering and it is not narrowly tailored to achieve the state's asserted interests.

[22] See *Cruzan*, 497 U.S. at 302 (Brennan, J., dissenting); *id.* at 339-40 (Stevens, J., dissenting) ("People are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions.").

the terminally ill who are institutionalized to obtain release from suffering unassisted; without aid, they are unable to obtain the means for a swifter death. Moreover, a state's blanket prohibition against aid in dying presents an absolute obstacle to those who do not wish to quit their lives until their terminal illnesses progress to the point at which they lack the very strength to accomplish suicide unassisted. One consequence is particularly intolerable. Faced with increasing weakness and loss of autonomy in the final stages of an illness, terminally ill patients who have chosen to avoid lengthy and excruciating deaths are frequently forced to end their lives prematurely for fear that further loss of strength or intense medical supervision effectively will deprive them of their choice.

Furthermore, such terminally ill patients often are driven to end their lives by violent means and entirely alone. Ironically, such violent means are often legally accessible, whereas the medical means that might allow the patient to quit life gently are now inaccessible in the absence of a physician willing to transgress the law. The fear of implicating one's friends or family in crime, moreover, often induces the terminally ill to carry out their resolve secretly and alone. The trauma is then magnified for friends and family who must deal not only with the death, but the gruesome means employed and the fact that their loved one was forced to meet death unsupported and alone.[23]

Other terminally ill individuals determined to end their suffering frequently turn for help to friends or family members, who must then choose between love and compassion or the dictates of the law.[24] Another cruelty caused by the ban on assistance is that

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[23] The ban on physician assistance may not only cause terminally ill individuals to commit suicide prematurely or preclude a gentle death or one in the company of friends and family, but it also may frustrate the very desire for certain death when self-inflicted attempts fail, thereby causing additional and gratuitous suffering to the tormented patient. See Quill, *supra* note 16, at 117-20.

[24] See, *e.g.*, K. Frederickson, *Torn Mother: I Helped Her Pass On*, Oregon Bulletin, May 16, 1994, at A1 (giving account of mother's explanation, after expiration of statute of limitations, of how she finally acceded to daughter's plea to assist her suicide after months of watching her wasting from bone cancer in too much pain to endure even her mother's touch).

non-physician assisted suicides are amateurish affairs, always clandestine and often bungled. One Canadian study of "back-alley euthanasia" among the Vancouver AIDS population found that one-half of assisted suicides were botched, perversely increasing — rather than alleviating — suffering.[25]

B. The States' Asserted Interests Do Not Justify an Absolute Ban on Physician Aid in Dying for the Terminally Ill.

In opposition to this right, Washington and New York invoke interests in preserving human life, precluding undue influence or mistake, safeguarding the integrity of the medical profession and a concern over the "slippery-slope" — *i.e.*, that line-drawing in this area will prove impossible. These interests and concerns, however legitimate, do not justify an absolute ban on physician aid in dying for terminally ill persons and should not outweigh the recognized right of a competent, terminally ill individual to end his or her suffering.

1. Interest in Preserving Each Citizen's Life

First, as this Court has determined, a state's interest in the preservation of every citizen's life, such as that asserted by New York and Washington here, abstracted from the value that a particular person may place on the continuation of that life, cannot outweigh a terminally ill individual's choice to end suffering and quit a life burdened by intractable pain and irreversible disintegration. See *Casey*, 505 U.S. at 857 ("[A] State's interest in the

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[25] See Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12. For example,

> In five cases, victims were unsuccessfully suffocated. In one case, the people who assisted in the suicide resorted to slitting the victim's wrists with a razor blade and in another case to shooting him. Two were injected with pure heroin. Many of the acts of euthanasia took several hours or longer to be completed. In one case it took four days.

Id.; see also Gina Kolata, *AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure*, N.Y. Times, June 14, 1994, at C1 (reporting on man who, in trying to bring on a gentle death by smothering his lover with pillow, asphyxiated him only enough to destroy most of his brain function).

protection of life falls short of justifying any plenary override of individual liberty claims.").[26]

Second, the pitiless process by which many terminally ill persons die — the unremitting pain, the erosion of privacy and dignity, the loss of control over basic bodily functions — leads some to conclude that the burden of their corporeal existence degrades the very humanity it was meant to serve. In choosing to end their suffering, the terminally ill do not repudiate an interest in life but seek to affirm a meaningful life with a dignified death.[27]

In these circumstances, a state may not insist that the terminally ill endure the unendurable in order to promote the state's abstract interest in the preservation of life. To do so is to appropriate an individual's existence, and to prolong cruel and unusual torment, for the purpose of proselytizing the state's preferred philosophical view of life. This a state may not constitutionally do.[28]

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[26] In *Cruzan*, the majority stated :

> we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

497 U.S. at 282. Indeed, a state has no other choice. More specifically, a state cannot make determinations about the worth or quality of an individual's life and then rely on that determination as a basis for making life or death decisions. For the terminally ill, the meaning of life and the impact of physical and psychological agony represent the most personal of judgments that the state may not usurp.

[27] As Justice Stevens noted, an interest in life "includes an interest in how [one] will be thought of after ... death by those whose opinions mattered" during life. "How [one] dies will affect how that life is remembered." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting). Those enduring a life racked with pain and utter helplessness may reasonably reject the prospect of a long vigil where family and friends loyally and lovingly witness their disintegration. The terminally ill reasonably may assert an interest in being remembered for how they lived rather than the excruciating, relentless and lengthy process by which they died.

[28] A state may not even use a person's car as a moving billboard to proselytize its views on life's meaning by insisting that the state's motto appear on citizens' license plates. See *Wooley* v. *Maynard*, 430 U.S. 705 (1977). In the abortion context, a state may not insist that a woman carry a not-yet-viable life to term to affirm the state's view of women's role or its philosophic view of when life

2. Preventing Undue Influence or Mistake

Washington and New York also rely on their interest in protecting vulnerable citizens. They argue that the right at issue, if recognized, would be subject to abuse and mistake — that requests for aid in dying would be mistakenly granted to those not terminally ill (because incorrectly diagnosed) or to those whose request was not truly voluntary (due to undiagnosed depression, lack of capacity, inadequately treated pain, or undue influence from family or physician).

These concerns, however, are not unique to the present situation. The risk of abuse or mistake exists in many medical contexts, including the end-of-life decisions already condoned by the State. These risks are routinely and appropriately dealt with through regulation. For example, only an informed competent adult may consent to an order not to resuscitate. See, *e.g.*, N.Y. Pub. Health Law §§ 2960 *et seq.* (McKinney 1993). Similarly, only a competent principal may appoint a health care agent (who may be a family member) who has the power to decide not to resuscitate or to terminate life support for the principal in the event of incapacity. See, *e.g.*, N.Y. Pub. Health Law § 2981 (McKinney 1993). Indeed, under applicable state statutes, a finding of competence is a necessary precondition to the execution of health care directives.[29]

If the law permits life-ending actions to be taken on the basis of competence in other medical contexts, there is no reason to claim that such a determination is impossible in this setting. Moreover, the recognition of the right to physician aid-in-dying would better address some of the state's concerns here. Whereas the current legal regime may lead the terminally ill to hide their wish for suicide from their doctor for fear that needed pain medication may be withheld, recognition of the right to physician assistance in hastening death would encourage frank discussion between the terminally ill considering suicide and their treating

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begins. See *Casey*, 505 U.S. at 851. Equally, a state may not promote its view of the sanctity of life by insisting that a terminally ill individual bear unrelieved suffering rather than hasten death.

[29] See generally *Compassion*, 79 F.3d at 818 (citing numerous statutes).

physician. Such discussions necessarily would raise the issue of the patient's mental state and the pain being experienced, and lead to the provision of treatment for depression, where warranted, or for pain, where all available methods have not been tried. Furthermore, where family or friends have improperly planted the thought of suicide, involvement of an objective physician would be salutary.

With respect to the concern over mistaken diagnosis (as with the previous concerns), safeguards short of an absolute ban can be crafted to minimize the likelihood of misdiagnosis to a very small order of probability.[30] Furthermore, the risk is equally present in other end-of-life decisions already condoned by the state such as the withdrawal or refusal of life-support by the terminally ill.[31]

Furthermore, the state's concerns regarding mistake in the exercise of the right ignore the consequences of a prophylactic outright ban on the terminally ill who are unquestionably competent and unquestionably in the end-stage of terminal disease. These terminally ill would be left acutely to suffer — having been foreclosed, as the United States acknowledges, from the "one

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[30] Model regulations have provided that a patient seeking physician assistance in hastening death receive confirmation by at least two physicians (or an entire committee of physicians) that they are in the terminal phase of their illness before such a request will be honored. See *infra* p. 22 & n.34.

[31] The United States argues that an incorrect diagnosis in the case of the withdrawal of life support d[illegible]ot, as it would here, result in death. See Govt. Br. in *Quill* at 14. In support, the United States points to Karen Ann Quinlan, who lived for years after her life support was disconnected. *Id.* But the Government's argument conflates two possibilities of misdiagnosis at stake in a terminally ill patient's decision to withdraw life-support and hasten death: dependence on life-support (not at issue in this case) and the terminal phase of an irreversible disease (which is at issue in this case). Withdrawing life-support does not lead to death where there has been a misdiagnosis of dependence on life support. On the other hand, where the misdiagnosis involves the reversibility of the disease (*i.e.*, whether it is terminal) — the only diagnosis at issue here — a misdiagnosis leading to withdrawal of life support will lead to a death. In such cases, a person whose condition might have improved if retained on life support, is removed from life support and allowed to die. Despite such risks (which can be and are minimized through requirements of diagnostic confirmation), the right to hasten death through directing the discontinuation of life support has been vouchsafed to the terminally ill.

humane and certain route of escape from pain and suffering." Govt. Br. in *Quill* at 15. These individuals, whose lives have already been so horribly compromised, cannot be forced to such a sacrifice.

Moreover, the current *unregulated* practice of assisted suicide by the terminally ill is clearly more subject to the abuse and mistake that concern petitioners and their amici. Existing back-alley methods provide no safeguards at all and thus no assurance that diagnosis will be accurate, that depression will be identified, and that undue influence has not been exercised. Yet, if the right claimed here is not recognized, certain terminally ill patients who are incapable of enduring further suffering will resort to self-help or the back-alley methods currently available with all of their significant risks.

Accordingly, amici urge recognition of the right claimed by respondents. Amici also support the use of legislative safeguards to ensure that all requests of the terminally ill for aid in dying are the product of thoughtful and informed self-determination.[32] Petitioners have offered no persuasive justification to support the need for a total prohibition.[33]

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[32] The recommendation of the New York State Task Force, relied on heavily by petitioners and their amici, is instructive in this context. In its 1994 report, *When Death Is Sought; Assisted Suicide and Euthanasia in the Medical Context*, the New York State Task Force on Life and the Law unanimously recommended that New York's statutory ban on assisting suicide be retained due to the risk of abuse and mistake if physician-assisted suicide for the terminally ill was allowed. In support of its recommendation, the New York State Task Force, like New York and Washington herein, focused on requests that were or might be made due to untreated pain or depression or undue influence. But when confronted with the specific issue raised by these cases — voluntary requests from the competent and suffering terminally ill — some Task Force members endorsed assisted suicide as a means of showing respect for the autonomy, and compassion for the suffering, of these patients. They preferred, however, that such patients obtain medical help clandestinely from courageous doctors willing to violate the law. See *id.* at 141. Thus, in the circumstances directly and solely at issue here, some members of the Task Force urged that the New York laws be disobeyed.

[33] The briefs of petitioners and their supporting amici rely on anecdotes (and selective studies — which are not uncontradicted — about experiences in another nation) to argue that regulation could not effectively safeguard the right claimed here. Notably, these anecdotes do not involve the exercise of the right to the

Indeed, several model statutes for physician assistance to the terminally ill already exist that incorporate procedural safeguards to screen out inappropriate cases, including requirements of: witnesses to ensure voluntariness (neither related to the patient nor involved in his or her treatment); reasonable waiting periods to preclude rash decisions; confirmation by a second physician of the terminal diagnosis and that the patient has been receiving proper palliative care; psychological examination to ensure that the patient is not suffering from a momentary or treatable depression; and reporting procedures.[34]

3. Implicating Doctors in Killing and Slippery-Slope Arguments

Petitioners and their amici also contend that affirming the decisions below will lead to the erosion of society's confidence in the medical profession by implicating physicians in intentional killings. But, as the Second Circuit correctly noted, the physician assistance sought by patient-plaintiffs in this case, "the writing of a prescription to hasten death ..., involves a far less active role for the physician than is required in bringing about death through" the withdrawal of life support. *Quill* v. *Vacco*, 80 F.3d 716, 729 (2d Cir. 1996). Accordingly, the right the patient-plaintiffs wished to exercise in this case implicates doctors in intentionally killing, and risks tarnishing their image, no more than does the currently

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refusal or withdrawal of life-sustaining treatment which *has* been effectively regulated. Instead, petitioners and their amici rely largely on hypothesized scenarios and anecdotes relating to the clandestine exercise of physician aid in dying, which at present is illegal and entirely unregulated. Neither these, nor the disputed experience of another nation, provide a sufficient basis to argue against the right urged here.

[34] See Oregon's Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1995); Michigan's Model Statue Supporting Aid-in Dying, appended to the Final Report of the Michigan Commission on Death and Dying (1994); New York, Senate Bill No. 7986 (May 3, 1994) entitled "Death With Dignity," sponsored by New York State Senators Galiber, Leichter, Markowitz, Smith and Waldon; Washington Senate Bill 5596 (Jan. 27, 1995) entitled "Terminally Ill Patient Act of 1995." Of course, the constitutionality of particular restrictions is not before the Court since the two state statutes in this case are both total bans.

sanctioned practice of removing life-sustaining medical treatment. See *Compassion*, 79 F.3d at 828 ("Given the similarity between what doctors are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession."). Furthermore, since safeguarding of the right at issue here will permit and encourage candid discussions of all available options between the terminally ill and their physicians, instead of "criminaliz[ing] the provision of medical assistance to patients in need," *id.* at 827, recognizing the right of the terminally ill to obtain the relief they seek from their doctors would foster rather than erode public confidence in the medical profession.

The other argument raised by petitioners and their supporting amici is that recognition of the right to physician aid in dying urged here would somehow be uncontainable. These sorts of slippery-slope arguments can be made in opposition to any constitutional right (and have been leveled against many recently recognized rights, including the right to terminate life-sustaining treatment). Recognition of any right creates the possibility of its abuse; but petitioners do not raise any cogent concerns that could not be addressed in ways that still allow the right to be exercised.

Finally, Petitioners point to the difficulty in defining the category of the "terminally ill." In fact, this term has been used (and defined) in "living will" statutes in effect in 40 states. See *Compassion*, 79 F.3d at 818 & nn.77-78 (listing state statutes). While the term is not free from difficulty, it has proved workable and is not problematically vague.[35]

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[35] Petitioners point further to the difficulty in distinguishing between a physician's prescription of lethal medication to be self-administered by a terminally ill patient and a physician's administration of that medication where the terminally ill individual is unable to do so. Amici acknowledge that some terminally ill patients who voluntarily request a hastened and gentle death may, due to the devastating progress of their disease, be unable physically to ingest medication without assistance. The question whether the physician's administration of the medication could be constitutionally prohibited in such a case is not presently before the Court. Amici, however, agree with the Ninth Circuit that the crucial question is whether the request is thoughtful and voluntary and, if so, the terminally ill patient who is physically unable to administer the medication that would release him from his agonies cannot, consistent with the Constitution, be

III.

BECAUSE TERMINALLY ILL PATIENTS ON LIFE SUPPORT HAVE THE RIGHT TO MEDICAL ASSISTANCE IN HASTENING DEATH, DENYING TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT MEDICAL ASSISTANCE IN HASTENING DEATH VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT

The arguments supporting the right urged here are further buttressed by the fact that New York, Washington and most other states have recognized the right of a competent, terminally ill patient to choose to end a dehumanizing process of dying by hastening inevitable death. Indeed, they have recognized the right to physician assistance in implementing this choice. Most states, however, have explicitly extended this right only to a limited category of terminally ill patients: those dependent on life-support, including life-sustaining hydration and nutrition, who are permitted to end their suffering by directing the termination of such treatment even where the express purpose of such action is to hasten death. Physicians who comply with these directives are immune from criminal liability. But other terminally ill patients, also facing imminent death but not undergoing such treatments, are not granted the right to truncate a dehumanizing and agonizing dying process and to embrace a swifter death through medical assistance.

The Equal Protection Clause mandates that "all persons similarly circumstanced shall be treated alike." *Royster Guano Co.* v. *Virginia*, 252 U.S. 412, 415 (1920). The Second Circuit recognized that, with respect to the decision to end intolerable suffering by hastening an inevitable death, all terminally ill persons are

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prevented from obtaining the necessary aid. See *Compassion*, 79 F.3d at 831-32. The fact that the right urged here may one day properly be extended to include such a case is no cause for alarm. It bears no relation to the entirely speculative, nightmare scenarios pained by certain amici supporting petitioners: that the right urged here — a right of the individual against the state for release from the unendurable ravages of terminal disease — somehow will metamorphosize into the ability of society to act against the individual and do away with those whose lives are no longer valued. Such dark fantasies should be disregarded.

similarly situated, whether or not on life support. But, by denying only those not on life support access to a medical means to achieve their desired end, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths." *Quill* v. *Vacco*, 80 F.3d 716, 727 (2d Cir. 1996). Accordingly, New York's laws (and their Washington equivalents) which prohibit only some terminally ill from obtaining an escape from their pain "are violative of the Equal Protection Clause." *Id.*

Petitioners argue that there is a constitutionally significant distinction between the withdrawal of medical treatment (even life-sustaining medical treatment) and the release from suffering sought by the respondents in this case. In fact, as the United States essentially acknowledges, see Govt. Br. in *Quill* at 10, 13, and as the Second Circuit found, see *Quill*, 80 F.3d at 729-30, there is no material distinction between the patient's choice in either case or between the physician's involvement in accomplishing that choice.

In both cases the patient is making the decision to curtail weeks or months of suffering in the face of further devastation and certain death. Terminally ill patients who request the discontinuance of life-sustaining treatment, like the terminally ill patient-plaintiffs who by this action sought to hasten death by consuming drugs prescribed for this purpose, have made a conscious decision to die and seek medical assistance to accomplish their desire.[36] The medical assistance required to implement this choice is far greater (both in terms of quantity of activity and causal nexus to death) than the prescription of medication to be self-administered by the terminally ill. In the case of the withdrawal of life support, the physician must remove the medical machinery sustaining life, monitor the resultant accelerated dying process and administer morphine or barbiturates to ease the pain that would otherwise

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[36] See *Quill*, 80 F.3d at 729 (citing *Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring)).

attend such a death. These medications typically must be administered in doses that in fact precipitate an even earlier death.[37]

Thus the Talmudic distinction petitioners press between the allegedly "natural" death accomplished by withdrawing life-sustaining treatment and the allegedly "unnatural" deaths sought here, is not sustainable. In both cases the motive force is the patient's intention to hasten impending and certain death and in both cases the physician provides the medical assistance to ensure that the patient's desire can be accomplished in a certain, gentle and medically supervised manner. As the Second Circuit rightly concluded in *Quill*, the withdrawal of life-sustaining treatment by the physician is not "passive" assistance to that desire nor does it allow for a "natural" death. See 80 F.3d at 729.

Petitioners' specious distinction between, and undue emphasis upon, natural and unnatural deaths has warped treatment decisions made by compassionate doctors wishing to respond to requests from terminally ill patients who are not on respirators or receiving artificial nutrition and hydration but who, nonetheless, have reached the limit of their endurance. In such cases, physicians sometimes have aided these patients by contriving a death that mimics those regarded by petitioners as "natural." This practice, sometimes referred to as terminal sedation, involves medicating the patient into a sleep-like state until the patient dies of starvation or dehydration, days or perhaps weeks later. See AMA Br. in *Glucksberg* at 10; Resp. Br. in *Quill* at section III.B.

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[37] The Second Circuit's discussion of this point bears repeating:

> [T]he writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill, 80 F.3d at 729.

Indeed, as part of palliative care for the terminally ill, doctors routinely have supplied the causal agent of patients' deaths under the doctrine of "double effect." Where the terminally ill suffer from intractable pain in the final stages of disease, doctors sometimes will choose to administer an intravenous morphine drip that eases suffering by inducing a sleep-like state and also hastens death by suppressing respiration; as with terminal sedation, death may be precipitated in a matter of days. Medical ethicists and the Catholic Church justify action such as terminal sedation and morphine drips on the ground of the "double effect," reasoning that the physician's operative intent is to relieve pain, while death is regarded as a foreseen but unintended consequence.

But the patients at issue in these cases also seek a release from suffering, and also believe that such relief can only be accomplished by their deaths. There is no constitutionally cognizable reason that the prescription of medication to eliminate suffering and achieve a peaceful death can only be legally permissible where death is accomplished gradually (by starvation, dehydration or asphyxiation) while the patient is put into a twilight zone that can last days or weeks. This option, where one is subject to the unknown sensory experiences and state of consciousness that might attend such a drug induced coma, while one's loved ones stand vigil for days or weeks, may appear a monstrous and horrifying prospect to the terminally ill who wish for a certain and gentle death.

Moreover, the practice of terminal sedation and intravenous morphine drip places the decision in the hands of doctors rather than patients.[38] Amici urge that the right pressed here — which is

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[38] Where a patient requests aid in dying quickly, the patient endangers the delicate excuse of the "double effect" and a doctor who otherwise might have employed a morphine drip may demur, afraid of running afoul of the criminal law. See Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A27.

also meant to relieve suffering by hastening inevitable death — better serves the needs and autonomy interests of terminally ill patients.

The distinction urged by petitioners between the competent terminally ill who wish to die and those who wish to terminate life-sustaining treatment (or who are willing to undergo terminal sedation) certainly cannot survive the heightened scrutiny required when fundamental rights are at stake and, as the Second Circuit found, its very rationality is difficult to ascertain.[39] In short, because a complete ban on the prescription of medication to competent terminally ill patients who wish to hasten death does not serve the state's expressed interest as well as would appropriately drawn regulations, it is violative of the Equal Protection Clause.

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[39] Interestingly, the United States suggests that this Court need not be especially vigilant in reviewing the state's line drawing here because "[t]erminal illness does not single out any discrete or insular minority; it potentially affects all Americans." Govt. Br. in *Glucksberg* at 31-32. On this basis, the United States asserts that "there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way," and also contends that "there is no indication that the political processes are malfunctioning." *Id.* at 31 & n.3. This argument fails, of course, if a fundamental liberty interest is at stake because, in that circumstance, heightened scrutiny is required regardless of whether a discrete and insular majority is involved.

Furthermore, as a matter of practice, it is difficult to put faith in the political processes which have traditionally not acted to safeguard the right of the terminally ill to escape pain through a gentle, hastened death while prosecutors, courts and juries have never meaningfully punished anyone for helping the terminally ill exercise this right. See *supra* p. 7 & nn.12-13. This disjunction between the law on the books and the law in enforcement bespeaks a malfunctioning of the political process.

CONCLUSION

For the foregoing reasons, Amici respectfully request that the judgments of the Courts of Appeals be affirmed and that the New York and Washington statutes prohibiting physician-assisted suicide be declared unconstitutional as applied to mentally competent, terminally ill persons requesting such aid to escape unendurable suffering.

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APPENDIX

Appendix

INTERESTS OF AMICI CURIAE

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution. Since its founding in 1920, the ACLU has participated in numerous cases before this Court. Of particular note here, the ACLU appeared as counsel in both *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 112 S. Ct. 2790 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). The ACLU of Washington is a state affiliate of the ACLU and appeared as amicus curiae before the Ninth Circuit in *Compassion In Dying* v. *Washington*.

The National Gray Panthers Project Fund is a civil liberties advocacy project concerned with social justice for the aging. As advocates for the aging, the Gray Panthers and their state affiliates of Washington and New York join in this case, as a friend of the court, to highlight the right of individuals to make choices about the quality of their lives.

The Japanese American Citizens League ("JACL") is a national civil rights organization founded in 1930, committed to strive to secure justice and equal opportunities for all Americans of Japanese ancestry as well as for all Americans, regardless of race, creed, color, national origin, religion, sex, sexual orientation, or disability. The JACL supports legislative initiatives that provide for the welfare of the broader community. The Pacific Northwest District of JACL also joins in this amicus brief as a advocate for the health care needs, as well as the death with dignity needs of its membership and of the total community, upholding the individual's right to freedom of choice on those matters that are essential to basic human dignity.

The Humanists of Washington is a freethought association dedicated to the principles of secular humanism. The group supports intellectual freedom, free inquiry, critical thinking, and civil liberties. Humanists of Washington's defense of civil liberties is unconditional; it works for the right of individuals to make personal decisions about their bodies free from unnecessary

government intrusion. Accordingly, the group defends, among other things, the right of terminally ill persons to choose the time and manner of their death.

The **Hemlock Society USA** was formed in 1980 to achieve the legalization of physician aid in dying for terminally ill, mentally competent adults. It has 25,000 members in 80 chapters and community groups throughout the country. The New York State and Washington State affiliates join the national organization in supporting the right of dying persons to work with their physicians so that the voluntary request for a hastened death may be part of the continuum of care available to the terminally ill.

The **Euthanasia Research & Guidance Organization ("ERGO!")**, a non-profit educational corporation organized under the laws of the State of Oregon, was founded in 1993 to lay the groundwork for the compassionate and just implementation of a mentally competent terminally ill adult's decision to hasten death when the law permits it in America. ERGO promotes safeguards and guidelines on legal, medical, and ethical issues so that physician aid in dying will be put into careful practice. Its goal is to educate and prepare individuals and institutions, ensuring a smooth transition when the change in law occurs. ERGO supports the respondents' position that a mentally competent terminally ill adult has the right to hasten inevitable death with the assistance of a physician.

AIDS Action Council is the Washington, D.C. representative of over 1,000 community-based organizations and the people living with HIV/AIDS they serve across the nation. As the only national organization devoted entirely to federal advocacy on behalf of people living with HIV/AIDS, AIDS Action works to ensure that effective national initiatives for prevention, care, and research are developed and implemented which are responsive to and respectful of the needs of all people living with or at risk of HIV/AIDS. In that regard, AIDS Action supports policies that empower people living with AIDS to exercise their fundamental right to make individual decisions about how they live with this disease, including their right to choose in a dignified and humane way the manner and time of their death with the assistance of their physicians.

The Northwest AIDS Foundation is the largest private, non-profit HIV/AIDS service and education organization in Washington state. The Foundation is dedicated to ensuring and maintaining the highest quality of life for persons living with HIV/AIDS, preventing the spread of HIV and advocating for all those whose lives have been affected by HIV/AIDS. Knowing the pain their clients experience as their illness becomes terminal, incapacitating, and untreatable, the Foundation supports the right of all persons with a terminal illness to decide for themselves when to end their own lives and for those individuals to seek assistance in doing so if they so wish.

The Seattle AIDS Support Groups ("S.A.S.G.") mission is to provide emotional support in a group setting (via support groups and a drop-in center) to persons living with HIV/AIDS and to their families, friends, and loved ones. The group's commitment is to create a safe and supportive environment fostering dignity, fullness of life and personal empowerment for persons with AIDS. By fostering dignity and personal empowerment, S.A.S.G. seeks to validate each individual's own choices about living and dying with this disease. The group believes that the option to hasten inevitable death should be a right for all terminally ill persons who elect to make that choice.

Local 6 of the Service Employees International Union ("Local 6") is a labor union representing 10,000 workers in Washington. As almost every improvement in the condition of working people has been accomplished by the efforts of organized labor and as the welfare of workers in Washington can best be protected and advanced by united action, the mission of Local 6 is to gather and expend its resources and to unite and empower its members for the advancement of working people. As a organization, Local 6 believes that people should exercise control over their lives and take responsibility for their decisions.

The mission of **Temple De Hirsch Sinai ("Temple")** is to serve the spiritual needs of its congregation through the observation, celebration, and study of reformed Judaism. It affirms the principles of reformed Judaism through its religious services, life

cycle ceremonies, religion school, social action, and outreach to individuals and families. The Temple promotes Jewish ideals in personal conduct, dedication, family and community life, and in its partnership with other institutions. Its interest comes under the tenets of the Old Testament, where all Jews are admonished to assist and share with the provision of food, clothing, and shelter for those less fortunate. The Temple's specific interest in this case is equal treatment of all citizens of this country.

The Older Women's League ("OWL") is a national organization working to better the lives of all midlife and older women. One of its agenda items is "Staying in Control Through All of Life." OWL works to improve policies and legal means to protect each individual's decision-making capability affecting quality of life until its ending. The Seattle/King County Chapter of OWL joins as amicus to support the right of the terminally ill to decide to end their suffering.

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State of Washington
v.
Glucksberg

Vacco
v.
Quill

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND AND NINTH CIRCUITS

Brief for the *Amici Curiae*: Gay Men's Health Crisis and Lambda Legal Defense and Education Fund: On Behalf of their Members with Terminal Illnesses; and Five Prominent Americans with Disabilities: Evan Davis, Hugh Gregory Gallagher, Barbara Swartz, Michael Stein and Susan Webb In Support of Respondents

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I. INTERESTS OF AMICI CURIAE[1]

People with disabilities do not speak with one voice on whether individuals with terminal illnesses should be permitted to end their own suffering with the assistance of their physicians and to choose a death with dignity. While some members of the disability community have been extremely vocal in opposing the right to assisted suicide, the majority of individuals with disabilities, including the *Amici* filing this brief, believe that such a right exists – that it is entirely consistent with our Constitutional tradition and the hard-fought rights secured by the disability rights movement in this country.

Amici are individuals and organizations representing people with a broad array of disabilities who share the common belief that individuals with disabilities should have autonomy over the decisions that affect their lives. They believe that the fundamental right of self-determination must apply to all significant life decisions, including what is perhaps the most intimate and personal decision of all, whether to hasten impending death if their conditions become terminal and they are suffering intolerably.

The two *Amici* organizations represent people who have AIDS, some of whom are in the terminal phase of their illnesses. The Lambda Legal Defense and Education Fund is a national non-profit public interest legal organization working for the civil rights of people with HIV and AIDS. The Gay Men's Health Crisis is the oldest and largest not for profit AIDS organization providing services to people with AIDS and their loved ones, educating the public and advocating for fair and effective AIDS policies. These organizations contend that the state should not be allowed to prohibit their members from receiving the assistance of their physicians in ending their lives when they have decided that life is no longer bearable.

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[1] Amici were granted consent to file this brief.

The individual *Amici* are leaders in the disability community or prominent individuals with disabilities. Evan Davis is a partner with a major national law firm who had polio at age five. Hugh Gallagher is one of the leading historians on disability in this country. Michael Stein is the former President of the National Disability Bar Association. Barbara Swartz is a professor who has kidney disease. Susan Webb is the director of an independent living center for people with disabilities and an elected member of a national disability rights organization. All have disabilities but not terminal illnesses, and believe that they should have the right to hasten their death should they ever become terminally ill. Their personal statements are attached as an appendix to this brief.

Amici believe that the Constitution guarantees people with terminal illnesses the right to end their lives in a manner that allows them to maintain personal dignity. The attempt of Petitioners and their *amici* to use disability to justify state deprivation of this fundamental right is deeply offensive to *Amici* and the thousands of people with disabilities they represent.

A. The Disability Rights Movement

The disability rights movement is a social movement with the goal of achieving independence and autonomy for people with disabilities in all aspects of their lives. Gerben DeJong, *Independent Living: From Social Movement to Analytic Paradigm*. 60 Arch. Physical Med. Rehab. 435 (1979).[2] Judy Heumann, one of the pioneers of the movement, co-founder of the World Institute on Disability and currently the Assistant Secretary for Special Education and Rehabilitation Services at the U.S.

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[2] The terms "disability rights movement" and "independent living movement" are often used interchangeably by members of the disability community. Whether they are two separate social movements or two names for basically the same movement is a matter of debate. For purposes of this brief, the broader term "disability rights movement" is used to refer to both.

Department of Education, expressed the driving spirit of the movement best in an early policy report:

> To us, independence does not mean doing things physically alone. It means being able to make independent decisions. It is a mind process not contingent upon a "normal" body.

Susan Stoddard Pflueger, *Independent Living: Emerging Issues in Rehabilitation*, foreword ii (December, 1977) (unpublished report on file with the Institute for Research Utilization).

Similarly, Edward V. Roberts, one of the founding fathers of the movement, made the following observation:

> I believe that the basic premise of the ... movement is that everyone has potential to live more independently. Our experience shows that **even the most severely and profoundly disabled individual can be independent – they may need all kinds of help – But that they can be in control of their lives.**

Id. at 1 (emphasis added).

Over time, the movement has been successful in altering the general belief in our society that people with disabilities are invariably vulnerable, exploitable, and incapable of making decisions that fundamentally affect their lives. Until recently, however, most people with disabilities accepted the predominant paternalism concerning disability and the control of their lives by other people, often to their detriment. It was only after three decades of political struggle, with the bipartisan enactment of The Americans with Disabilities Act of 1990 (the ADA)[3] that our nation developed a consensus that competent adults with disabilities can and should exercise control of their lives in the mainstream of our society.[4]

Among the rights that the movement has secured for people with disabilities are the right to live in the community, as opposed to in isolated, degrading and disempowering institutions, *Youngberg v. Romeo*, 457 U.S. 307 (1982); the right to be free of involuntary sterilization, *Relf v. Weinberger*, 372 F. Supp. 1196 (D.C.D.C. 1974), the right to raise a child, *In re Marriage of Carney*, 598 P.2d 36 (Cal. 1979); the right to have access to public streets, public transportation, schools, public services, privately owned places of public accommodation and places of employment, 42 U.S.C. §§ 12111-12181; and the right to a free and appropriate education, 20 U.S.C. § 1400 *et seq.* (1991).[5]

Entirely consistent with these rights is the right to control one's death when it is imminent – arguably the most fundamental right of all.

B. The Views of People with Disabilities

According to a major public opinion poll, 66 percent of people with disabilities support the right to assisted suicide, as compared with 70 percent of the general population. Louis Harris and Associates, Harris Poll no. 9, Table 105 (1995). This result is corroborated by a recent study which found that 63 percent of people with AIDS support this right, and 55 percent actually have considered this option for themselves. William

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[3] The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).

[4] *See generally*, Jane West, ed., THE AMERICANS WITH DISABILITIES ACT: FROM POLICY TO PRACTICE (1991); Jane West, ed., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT (1996); Mark Nagler, PERSPECTIVES ON DISABILITY (2nd ed. 1993); Lawrence O. Gostin & Henry A. Beyer, eds., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT: RIGHTS AND RESPONSIBILITIES OF ALL AMERICANS (1993).

[5] The Individuals with Disabilities Education Act (IDEA).

Breitbart, et al., *Interest in Physician-assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238 (1996). Another study found that 90 percent of people with AIDS support the right. Brett Tindall et al., *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. Acquir. Immune. Defic. Syndr. 1069 (1993).

While resolution of this issue by a poll of those most affected would quickly end criminalization of assisted suicide, constitutional issues are not rightly settled by popular vote. The personal and religious views of those who support either side of this national debate are immaterial to the question of whether patients who are terminally ill have a constitutional right to receive such assistance. However, the experiences and treatment realities of those who have lived with disabilities, including cancer and AIDS, are relevant to the Court's analysis. These experiences provide an explanation of why a decision, and request for assistance in accelerating death, is a legitimate treatment option which merits Fourteenth Amendment protection.

The experiences of those involved in the treatment of AIDS are particularly illustrative. Since the beginning of the AIDS epidemic in the early 1980s, people with AIDS and their advocates and service providers have been committed to ensuring that an individual with AIDS has as much autonomy in his or her life as possible. Many living with this disease have been involved decision makers in each stage of their treatment. In striving to maintain control over their lives as their physical conditions deteriorate, they have made increasing use of legal planning documents such as health care proxies and powers of attorney to maintain control of their final days. The right to end their lives with the assistance of their physicians is a natural extension of their efforts to maintain autonomy. The state's intrusion, effectively forcing a person to continue living against his or her will, destroys the autonomy that has been central to the struggles of people with disabilities.

Based on their experiences, it is clear that people with disabilities, like the public at large, believe that the state should

not be allowed to interfere with a terminally ill individual's personal decision of how and when to die. This important fact has been obscured by the vocal minority of those disability leaders who adamantly oppose recognition of the right to assisted suicide. Given the above statistics and the hard-fought battle for people with disabilities to win their autonomy, it is anomalous that some, purporting to represent the interests of people with disabilities, are advocating in favor of the state's right to interfere with the individual's autonomy.

In essence, those disability rights advocates opposing the right to assisted suicide appear to be saying that the individual with a disability should have control over every decision in his or her life, except for the decision of whether to live in the face of a terminal illness. This blatant contradiction is glaring and unacceptable to a substantial majority of people with disabilities.

C. The Interests of People with Disabilities

The interests of *Amici* are similar to the interests of millions of people with disabilities throughout this country. Although the personal circumstances of people with disabilities vary substantially, they share a common interest in maintaining control over their lives, including the ability to choose a dignified death.

The disabilities of some individuals, such as the individual *Amici*, will never be life-threatening or reach a terminal phase. To these individuals, issues concerning assisted suicide are the same as those for anyone else, except that some have a greater physical need for assistance. Like people without disabilities, these *Amici* want the right to make this choice for themselves if they someday become terminally ill. They do not want to be deprived of this right simply because they have disabilities. Nor do they want their disabilities to be used by others to justify a wholesale denial of this right.

Other individuals have disabilities which are more likely to become life-threatening, such as the individuals with AIDS represented by the two *Amici* organizations. For these *Amici*, the issue of whether there is a right to obtain physician assistance in

hastening death has a more immediate and direct impact. *Amici* in this situation want to be able to retain autonomy in making decisions about whether or when to end irreversible suffering if their illness or disability enters a terminal phase.

All *Amici* have a significant interest in how this issue is resolved. While not all are certain whether they would ever decide to hasten their own deaths, all want the freedom of knowing that this option will be available if the worst were to occur. Further, they want the security of knowing that they can exercise this option safely, effectively and legally with professional assistance. *Amici* believe that this would be a uniquely personal, moral and religious decision, one that would primarily impact themselves and their loved ones – a decision that they should have the right to make for themselves without undue state interference.

In his personal statement, *Amicus* Evan A. Davis expresses concern that this Court may be misled by disability organizations claiming recognition of a right to die with the assistance of one's physician would harm people with disabilities. He points out:

> The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

Personal statement of Evan A. Davis.

II. SUMMARY OF ARGUMENT

Like others in our society, people with disabilities wish to define their concept of existence, and to have autonomy over the uniquely personal decisions that effect their lives. Unlike most

other people, many of their basic rights have been denied until very recently. After having fought for their rights for so long, and having achieved recognition through enactment of the ADA as citizens fully capable of autonomy, they are offended that, on the basis of their disabilities, others are attempting to deny them and all other Americans the right to end their lives with dignity if they become terminally ill.

People with terminal illnesses have a liberty interest under the Fourteenth Amendment to end their lives with the assistance of their physicians, if they so choose. This liberty interest must be considered fundamental. It is at least as strong as other liberty interests recognized by this court, such as the right to terminate life support. Specifically, the current cases involve the right of an individual who is acutely aware of his or her suffering and impending death, and whose decision to hasten death by a few days or weeks does not harm the interests of any other person or potential person.

Assuming that the right is fundamental, the blanket prohibition in this case denying the right to all terminally ill individuals is not a narrowly tailored restriction necessary to achieve a compelling state interest. In fact, there is no compelling state interest in denying a person who is suffering and has little life left from ending his or her life with dignity. Any interests that the state has in denying the right are significantly outweighed by the interests of the individual. All legitimate state interests, such as ensuring competence, preventing coercion, and avoiding abuse, may be achieved through state regulation that does not unduly interfere with the basic right.

All objections raised by members of the disability community who oppose recognition of the right are either misplaced or may be addressed through appropriate regulation. Contrary to their assertions, neither the liberty interest in hastening death with physician assistance nor the diminished state interest in preventing this from occurring is in any way based upon quality of life considerations being imposed on the individual. It is derived from the autonomy of terminally ill

individuals to determine whether they wish to continue to live with their suffering for the brief remainder of their lives.

Moreover, any objections based on the Equal Protection Clause and the ADA lack merit. Terminally ill individuals are not similarly situated to people who are not terminally ill. They are dying, soon and often in great pain, and the right to end their suffering and control their deaths is a significant benefit to them. Giving them that respect does not deny them the protection of the state and does not discriminate against them in any way.

In contrast, as the Second Circuit found, competent, terminally ill individuals are similarly situated to people on life support who, when competent, indicated that they did not wish to live under those circumstances. Denying terminally ill individuals the right to assisted suicide violates the Equal Protection Clause.

In a compassionate society that respects the autonomy of people with disabilities, we must not deny people with terminal illnesses the right to end their suffering. For these individuals, physician assistance is the only means by which to ensure that their lives will end in a safe and humane manner.

III. ARGUMENT

A. PEOPLE WITH DISABILITIES ASSERT THAT PEOPLE WITH TERMINAL ILLNESSES HAVE A CONSTITUTIONAL RIGHT TO HASTEN INEVITABLE DEATH WITH THE ASSISTANCE OF THEIR PHYSICIANS

1. Competent, Terminally Ill Adults Have a Strong Liberty Interest Under the Fourteenth Amendment in Making End-of-Life Decisions Free of Undue Government Interference[6]

Because of the long struggle for recognition of their autonomy, the Fourteenth Amendment's Due Process limitations on the state's ability to intrude into the most important and personal matters of our lives has particular importance to people with disabilities. *Amici* agree with the Ninth Circuit that there is a liberty interest in determining the time and manner of one's death, and that "[c]ertainly, few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 813 (9th Cir. 1996).

Amici further agree with the Ninth Circuit's application of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (*aff'g Roe v. Wade*, 410 U.S. 113 (1973)) and *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990)). The right to "define one's own concept of existence," found in *Casey*, 505 U.S. at 851, and to

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[6] Although the Ninth Circuit decided this case on the basis of a Fourteenth Amendment liberty right, and this brief will focus on that right, Amici believe that there are additional bases for finding a right to assisted suicide. In particular, they contend that there is a strong privacy right in the Constitution for people with terminal illnesses to be protected from state intrusion. As Justice Brandeis stated in his famous dissent in *Olmstead v. United States*, 277 U.S. 438, 478 (1928), the framers of the Constitution "conferred, as against the government, the right to be left alone--the most comprehensive of rights, and the right most valued by Civilized men." In addition, at least one commentator has argued that a Fourteenth Amendment property right in one's body precludes state prohibition of assisted suicide. Roger F. Friedman, *It's My Body and I'll Die if I Want To: A Property-Based Argument in Support of Assisted Suicide*, 12 J. Contemp. Health L. & Pol'y 183 (1995).

have autonomy over the "uniquely personal decisions" that affect their lives, found in *Cruzan*, 497 U.S. at 281, are extremely important to people with disabilities. Where for generations, almost every aspect of their existence was defined by a paternalistic society that labeled them inferior and relegated them to institutions, they are unwilling to relinquish their autonomy.

This Court has previously found that a liberty interest is implicated when an individual is subject to state-imposed pain and suffering, even when such pain and suffering involves no more than a student being paddled for disciplinary purposes. *Ingraham v. Wright*, 430 U.S. 651, 674 (1977). In the current cases, the states are effectively forcing terminally ill individuals to incur severe pain and suffering. The state's interest in preventing the individual from escaping this anguish is minuscule.

The liberty interest asserted here is also no less compelling than that in *Cruzan*, where this Court recognized a competent individual's liberty right to refuse medical treatment and obtain active medical assistance in withdrawing existing treatment even when this will result in death. *Cruzan*, 497 U.S. at 261. Here, Respondents and *Amici* seek recognition of a right for terminally ill individuals to obtain medical assistance that will likewise cause death. While Nancy Cruzan could have lived for years unconscious on life support, the individuals in this case were fully conscious of their brief remaining life, their pain and suffering, and their desire to end their suffering.

2. The Second Circuit Implicitly Agreed With the Ninth Circuit That There is a Liberty Interest for People with Disabilities (and Other Individuals) With Terminal Illnesses in Hastening Their Own Death

Although the Second Circuit decided *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), based on the Equal Protection Clause of the Fourteenth Amendment, it is clear from its language that there is a due process liberty interest in deciding when and how to die. *Quill*, 80 F.3d at 725. In discussing "the protection of minorities,

the poor, and the non-mentally handicapped," the court concluded that "[i]n point of fact, these persons themselves are entitled to hasten death by requesting [withdrawal of life support] **and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness**. *Quill*, 80 F.3d at 730 (emphasis added).

As one commentator concluded, "[t]he Second Circuit ...says that no such liberty interest exists, yet in effect bases its Equal Protection Clause analysis on the existence of just such an interest." Christopher N. Manning, *Live and Let Die? Physician-Assisted Suicide and the Right to Die*, 9 Harv. J.L. Tech 513, 515 (1996). Thus, while certiorari was granted in this case in part due to differences in the reasoning of the two Circuit courts, there seems to be greater agreement between the Circuits that there is a liberty right to assisted suicide than is apparent from the Second Circuit's holding.

3. The Liberty Interest Asserted Here Is Fundamental and May Not Be Impaired Without a Compelling State Interest

These cases are about the ability of a terminally ill individual to die with dignity; however, they are equally about whether we, as a society, believe that the state should be allowed to impose itself at the patient's deathbed, between the patient, family members and the physician, as an equal medical decision maker. They are about whether terminally ill individuals are accorded the respect they deserve in making what may be the most difficult decision of their lives, and whether the state may incarcerate their physicians for honoring their request.

Amici believe that the ability of the state to intrude in and interfere with the final wishes of a dying person is unacceptable in a free society. They contend that the decision of terminally ill individuals to select the time and manner of their deaths cannot be infringed upon by a state without a compelling state interest that is achieved through a narrowly-tailored restriction. *Reno v. Flores*, 507 U.S. 292, 301-02 (1993). *Amici* agree with Justice Stevens, who in his dissent in *Cruzan*, concluded "[c]hoices about

death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental..."[7] *Cruzan*, 497 U.S. at 343 (emphasis added).

4. There is No Compelling State Interest in Denying Terminally Ill Individuals the Right to Die, and the Liberty Interest of the Individual Substantially Outweighs Any State Interests

If this Court finds the interest being asserted here is fundamental, as *Amici* contend, any restriction on pursuing that interest must be narrowly tailored to further a compelling state interest. *Reno*, 507 U.S. at 301-02. The restrictions being considered are not narrowly tailored; they fully preclude individuals from obtaining the assistance of their physicians in hastening their death. Moreover, there is no compelling state interest that would justify the denial of the final wish of a suffering terminally ill individual to end his or her life with dignity.

If, on the other hand, this Court finds the interest asserted is only important, it must be balanced against other relevant state interests. *Cruzan*, 497 U.S. at 279; *Youngberg*, 457 U.S. at 321. After an exhaustive analysis of all relevant state interests, the Ninth Circuit found that the balance weighs heavily in favor of the individual. *Compassion in Dying*, 79 F.3d at 799. *Amici* agree with this analysis, and wish to add only that the interests of the state in protecting competent people with terminal illnesses (or people with other disabilities) is no greater than its interest in protecting other competent individuals.

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[7] Justice Stevens further found that "... not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience." *Id.* *Amici* strongly agree. *See* Statement of Amicus Evan Davis.

Amici recognize the legitimate interest of the state in protecting and preserving life. The interest in protecting life is best furthered by ensuring that the decision to end life with the assistance of a physician, is made voluntarily, by a competent, terminally ill individual. The state always has this interest and may pursue it through effective regulation.

However, the state's interest in *preserving* life diminishes, and the interest of the individual to be protected from state intrusion increases, as the potential for life diminishes. *In Re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom* 429 U.S. 922 (1976). *Garger v. New Jersey*, 429 U.S. 922 (1976). The interest of the terminally ill individual in ending his or her suffering far exceeds that of the state in preserving what little life remains.

While *Amici* recognize the legitimate interests of the state in protecting individuals from the actions of others, they and the majority of people with disabilities in this country do not want the protection of the state from their own actions and decisions.

5. The Legitimate State Interest in Protecting People with Terminal Illnesses or Other Disabilities from Abuses Can Be Protected Through State Regulation

The state has a legitimate interest in ensuring that all individuals who seek physician assisted suicide are competent adults who have made their decision voluntarily, without coercion or undue influence. In addition, the state may legitimately seek to ensure that the individual has had access to medical or psychological counseling and is fully aware of his or her options. *See* personal statement of *Amicus* Barbara Swartz.

A state may enact rules to protect state interests so long as they do not impose an undue burden "with the purpose or effect of placing a substantial obstacle in the path of" the ability to make the constitutionally protected decision. *Casey*, 505 U.S. at 877. In the context of physician assisted suicide, the state may not regulate with the purpose or effect of placing a substantial

obstacle in the path of a terminally ill individual to end his or her life with the assistance of a physician.

There are, however, clear measures a state might take to protect its legitimate interests. In particular, as long as it does not cross over the substantial-obstacle line, a state might impose the following safeguards:

- requiring the individual to repeat the request on more than one occasion;
- requiring the request to be made to more than one doctor;
- requiring the individual to be provided an opportunity to discuss the decision with a mental health professional;
- requiring the individual to be informed of programs and resources that are available to improve the quality of his or her remaining life; and
- requiring the individual to be informed on several occasions that he or she may, and is encouraged to, change his/her mind at any time.

These illustrate several of the requirements a state would be allowed to impose to protect its legitimate interest in ensuring competent, voluntary decisions and preventing coercion to choose hastened death. In addition, states may require hospitals, nursing homes, and other medical institutions to report on their compliance with these requirements.

Amici are committed to ensuring that the right of terminally ill individuals to obtain physician assistance in dying with dignity is not abused, that all individuals who choose to hasten their deaths do so freely, without pressure or coercion, and that they are aware of available options should they choose to continue to live. *See* personal statement of *Amicus* Susan Webb.

B. THE RIGHT TO ASSISTANCE IN DYING WILL BENEFIT PEOPLE WITH TERMINAL ILLNESSES, AND WILL NOT ADVERSELY AFFECT OTHER PEOPLE WITH DISABILITIES

1. Neither the Strong Liberty Interest in Hastening Death, Nor the Diminished State Interest in Interfering With This Decision, Are Based on Any Externally-Imposed Quality-of-Life Considerations

Some disability organizations that oppose the right to assisted suicide contend that the right is based on a social perception that people with terminal illnesses and other disabilities have a diminished quality of life. This contention is inaccurate. The strong liberty interest of terminally ill individuals in controlling the circumstances of their deaths, and the diminished state interest in interfering with this decision, are derived from their autonomy in making decisions about what little remains of their lives.

The interests do not derive in any way from any perceived diminished quality of life for individuals with disabilities or terminal illnesses. Quality of life is a subjective valuation belonging to the individual, not the courts or the states. Whether the quality of the life remaining for a terminally ill person is sufficient to justify whatever pain and suffering he or she may be enduring is a decision for that person, and that person alone.

2. The Right to Hasten Inevitable Death is a Benefit for People with Terminal illnesses That is Not Prohibited By Either the Equal Protection Clause or the Americans with Disabilities Act.

Some opponents of the right argue that it would deprive people with disabilities of the equal protection of the laws and would otherwise discriminate against them in violation of the ADA. These arguments are based on a fundamental

misunderstanding of the right. They characterize the benefit to terminally ill individuals of a right to hasten their own death as the discriminatory denial of a statutory right to be protected from their own decisions to end their lives. Regardless of this flip-flopped reasoning, the majority of people with disabilities regard the right to death with dignity as a benefit, not a legal detriment.

The Equal Protection Clause of the Fourteenth Amendment commands that no state shall "deny to any person within its jurisdiction the equal protection of the laws," which essentially means that all persons who are similarly situated should be treated alike.[8] *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 439 (1985). The threshold question is whether people with terminal illnesses are similarly situated to non-terminal individuals with respect to their interest in dying. The answer is clearly no. Terminally ill individuals who are at the end of their lives, often with severe pain and suffering, have a different interest in end-of-life decisions than others.

[8] It is currently not clear what standard of review should apply to legislative classifications based on disability for purposes of equal protection analysis. On the one hand, the Supreme Court clearly found that people with mental retardation (perhaps the most vulnerable group in the disability community) are not entitled to heightened scrutiny. *Cleburne*, 473 U.S. at 422. On the other hand, *Cleburne* was decided in 1985, prior to the Congressional finding in the enactment of the ADA that "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society based on characteristics that are beyond the control of such individuals . . .." 42 U.S.C. § 12101(a)(7). Based on this finding, this Court may find that legislative classifications based on disability must receive the highest level of scrutiny. *Cf. Trautz v. Weisman*, 819 F. Supp. 282 (S.D.N.Y. 1993). Whichever standard this Court decides to apply, the right of terminally ill individuals to end their lives does not violate the Equal Protection Clause for reasons discussed herein.

Moreover, given the nature of the right at issue here, it is more appropriately viewed as an interest held by all individuals that may be exercised as a right if and when they become terminally ill, rather than a right held by terminally ill individuals and not others. Terminal illness, like disability generally, does not discriminate; it may affect anyone. Denying people who are not terminally ill the right to end their lives with physician assistance, until such time that they become terminally ill, does not deny them equal protection.

The second question is whether the right to assisted suicide deprives people with terminal illnesses of a benefit that is available to other individuals. Again, the answer is no. The right being asserted here would give terminally ill individuals an additional choice that they currently do not have. It would not require them in any way to exercise that choice. It would not deprive them of life. It would not deprive them of protection from murder. It would not deprive them of state suicide prevention services. In fact, it would not deprive them of anything.

The ADA prohibits actions by or policies of public entities that "exclude from participation in" or "deny the benefits of" any program, service, or activity of a public entity or by which persons are "subjected to discrimination by any such entity." 42 U.S.C. § 12132. Again, the right being asserted does not deny any benefit to any person with a disability, nor does it exclude any person with a disability from participation in any state program, service or activity.[9] The ADA was not intended to

[9] The one way in which the ADA may be applicable, however, is with respect to individuals with terminal illnesses who are not capable of self-administration of the lethal drug. Certain people with disabilities, such as some people with quadriplegia, have physical limitations which severely restrict or render impossible the ability to self-administer drugs. Modern technology has resolved this issue for the vast majority of these individuals through the development of assistive devices that allow them to self-administer. However, to the extent that

(continued...)

prevent people with disabilities from having greater options than other people, particularly when they are entirely free not to exercise those options.

Moreover, the ADA was not intended to protect people with disabilities from their own decisions. One form of discrimination against people with disabilities explicitly mentioned as a basis for the ADA is "overprotective rules and policies." 42 U.S.C. § 12101(5). Terminally ill individuals have a particularly strong liberty interest in not being "protected" by the state from their own end of life decisions. The right to obtain physician assistance to hasten their death is a significant benefit to them. They do not want protection from this choice.

3. The Standard of Terminal Illness Will Allow States to Prevent People Who Are Not Terminally Ill from Ending Their Lives With Physician Assistance

Some disability organizations that oppose assisted suicide contend that this right inevitably will be expanded to people with disabilities who do not have terminal illnesses. There is no reason this will occur. The requirement that the individual seeking to end his or her life must have a terminal illness that makes death imminent and inevitable is readily capable of definition and implementation. Many states and model codes define the term "terminal illness." Brief of Respondents *(Glucksberg)* at 32.

The fact that there is no uniform definition for "terminal illness" is of little consequence. At this stage, we need only consider the broad parameters of the right. In the current cases,

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9(...continued)
some of these individuals who are terminally ill are incapable of self-administration even with an assistive device, the ADA would probably require that the individual be permitted the assistance of his or her physician in administering the drug. Such administration would be entirely consistent with the active role that physicians currently play in conducting abortions and in terminating life support systems.

all people with terminal illnesses are precluded from obtaining the assistance of their physicians in ending their lives. This blanket prohibition clearly violates the liberty rights of many individuals who are, without any doubt, terminally ill. As long as a state defines terminal illness within the bounds of reasonableness, it may prevent people who fall outside those bounds from obtaining assistance in dying.

Some opponents point to the Netherlands as proof that the right to physician assisted suicide cannot be contained to people with terminal illnesses. Any such comparison is misleading. In the Netherlands, physician-assisted suicide is not allowed by statute, but physicians who adhere to official guidelines will not be prosecuted for assisting patients who request assistance in dying. However, those guidelines have never required that the patient be terminally ill or that the patient's suffering be physical. Chris Docker, *Euthanasia in Holland*, ¶ 1 (1996) <http://www.euthanasia.org/ dutch.html>.

Two recent studies of doctor-assisted death in the Netherlands suggested that tolerance of the practice has not produced the "slippery slope" leading to abuses which critics have predicted. P.J. van der Mass, et al., *Euthanasia, Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 N. Eng. J. Med. 1699 (Nov. 28, 1996); G. Van Der Wal et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 N. Eng. J. Med. 1706 (Nov. 28, 1996); M. Angel, *Euthanasia in the Netherlands – Good News? Or Bad?*, 335 N. Eng. J. Med. 1676 (Nov. 28, 1996).

The situation in the Netherlands, therefore, provides no support for the proposition that the right limited to terminally ill individuals in our country will necessarily be expanded.

4. The Standard of Voluntariness Will Allow States to Ensure Only Competent Individuals Who Choose to Hasten Death With Assistance Are Allowed to Do So

Opponents of the right to die further assert that people with disabilities will be induced to end their lives by others who consider them inferior or a burden. However, the right asserted here is based entirely on the voluntary choice of a competent individual with a terminal illness to end his or her life. As discussed above, the state is free to enact regulations to ensure that the decision is made voluntarily by a competent adult who was not subject to coercion or undue influence. Despite such standards, opponents contend that this right will be extended to incompetent individuals. They base this conclusion on case law concerning the right to refuse life-sustaining medical interventions. However, such expansion is by no means inevitable and may be precluded by this Court's decision.

The liberty right to assisted suicide is different from the right to withdraw life support. While competent individuals in both situations are similarly situated for purposes of equal protection analysis, the right to withdraw life support is based fundamentally on the common law right to be free from bodily invasions. *Cruzan*, U.S. at 269. The courts have appropriately found that, like competent individuals on life support, incompetent individuals have a right to be free from such invasions. The right to assistance in dying is based on the interest of the terminally ill individual to control his or her life. Because the right is based on the autonomy of the individual, it may be limited to those individuals who are capable of autonomy–competent adults.

5. In the United States, the Right of Terminally Ill Individuals to Choose Assisted Suicide Will Never Be Converted into a Right of the State to Authorize the Murder of People with Disabilities

Some organizations that oppose physician assisted suicide for competent patients who are dying and suffering contend that this is the first step toward a society in which life is devalued and people with disabilities are routinely killed by their doctors. These groups point to the "euthanasia" program authorized by

Nazi Germany in the 1930s as a graphic example. There are several serious problems with this analogy.

First, our country is not Nazi Germany; ours is a nation dedicated to individual freedom in which the state is constitutionally limited in depriving individuals of life, liberty or property and the press is constitutionally empowered to inform the citizenry of abuses of state power. The notion that the state will have an interest in killing, or authorizing the killing of, people with disabilities is ludicrous. One could just imagine the TV coverage of such abuses on the evening news, or "60 Minutes", as well as the criminal and civil legal actions that would inevitably follow.

Second, the Nazi program did not begin by granting a right to assisted suicide for people with terminal illnesses. It began with a determination by the state that people with disabilities are inferior, have an inferior quality of life, and are therefore disposable. That determination was in fact entirely consistent with the goals and ideals of the Nazi party, and flourished when the party flourished. By contrast, the notion that people with disabilities may be killed without their consent is, and will always be, abhorrent to the American public. The false notion that they are inferior or necessarily have an inferior quality of life may never in this country serve as a basis for any public policy, particularly a policy that would deprive them of life, liberty or property. The right being sought here is not in any way based on any perceived inferiority, or inferior quality of life of, people with terminal illnesses.

Third, and most important, the state in Nazi Germany gave the medical profession unbridled power and authority to control the lives and deaths of individuals with disabilities. In current cases, Respondents and *Amici* seek to expand individual autonomy and liberty, and to diminish the power and authority of the state to make or authorize decisions concerning the life and death of an individual. The implication of recognition of a right to assisted suicide is, therefore, not that the state will have more

power to take the life of any of its citizens, with or without disabilities, but rather that it will have less power.

Amicus Hugh Gallagher, author of *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich*, and one of the world's foremost experts on the Nazi euthanasia program, describes in his personal statement how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living," and that the patients were given no choice over whether to live or die. In indicating his support of the right to assisted suicide, he concludes that:

> The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. . . .
>
> The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability....
>
> To my mind, the issue comes down to control – control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set

> by their physicians with the concurrence of the state. This must never happen here.

Personal statement of Hugh Gregory Gallagher.

C. DENIAL OF THE RIGHT TO ASSISTANCE IN DYING WOULD DENY PEOPLE WITH TERMINAL ILLNESSES THE EQUAL PROTECTION OF THE LAWS

While the people with terminal illnesses in these cases are not similarly situated to people who are not terminally ill for purposes of the Equal Protection Clause, they are similarly situated to competent people on life support who have clearly indicated that they do not wish to live under such circumstances. *Amici* agree with the decision of the Second Circuit that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Quill*, 80 F.3d at 729. *See*, personal statement of *Amicus* Barbara Swartz.

D. A COMPASSIONATE SOCIETY THAT RESPECTS PEOPLE WITH DISABILITIES MUST NOT DENY TERMINALLY ILL INDIVIDUALS THE RIGHT TO END THEIR SUFFERING WITH ASSISTANCE

People with terminal illnesses have an immediate and urgent liberty interest in the right to hasten their death with the assistance of their physicians, whether or not they decide to exercise that right. Diseases such as cancer and AIDS may cause great pain and suffering, physical deterioration, and mental anguish. A society that cares about these individuals and that respects their autonomy must not deny them the opportunity to shorten the period of their suffering and to die with dignity in a safe and effective manner, with the assistance of their physicians.

1. The Decision of a Competent, Terminally Ill Individual to End His or Her Life Must Be Assumed to Be Rational and Should Be Respected

In our legal system, the decisions of competent individuals are presumed to be rational.[10] This presumption applies to the decisions of people with disabilities, and any contrary assumption by a state in establishing its policy would violate the ADA and our national policy concerning people with disabilities. Therefore, a state may not assume that the decision of a competent terminally ill individual to end his or her life is irrational and may not base a policy precluding assisted suicide on such an assumption.

Yet, some disability rights advocates who oppose the right to die seem to argue that people with disabilities are not capable of autonomy for purposes of determining when and how they should die when facing death with a terminal illness. The reason for this apparent inconsistency with their basic philosophy is that, they contend, many people with disabilities have so few resources or viable options that they cannot make a rational choice to end their lives. This inconsistency is unacceptable to *Amici* and the majority of people with disabilities.

Amici are leaders in the disability community who are committed to improving the lives of all people with disabilities and to enhancing the options available to them. They agree that our society often does not provide the support necessary for people with disabilities to live independently in their communities. However, the fact that the circumstances of the disabled population are, as a whole, far less than ideal in this country, and are likely never to be perfect, is no justification for depriving those who have a terminal illness of the right to end their suffering. These individuals are entirely capable of making rational decisions. *See* personal statement of Susan Webb.

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[10] *See, H.L. v. Matheson*, 450 U.S. 398, 453 (1951); *Davis v. United States*, 160 U.S. 469, 477 (1895).

As indicated above, between 66 and 90 percent of people with AIDS support the right to assisted suicide. Significantly, the study that found that more than half (55 percent) have considered this option for themselves, also found that the strongest predictor of interest in physician assisted suicide was having witnessed terminal illness in a family member or friend. Breitbart, *supra* at 242; Tindall, *supra* at 1069. This suggests that these individuals know from personal experience the pain and suffering a terminal illness can impose, and have concluded that a person should have the right to end that agony if they so choose. According to one observer:

> Patients who are dying of cancer and wish to lessen their suffering raise the concept of rational suicide. They are competent to make decisions, feel that they have completed their contribution to the world, and are unlikely to contribute anything more in the few weeks remaining. The disease is advanced and advancing, and they understand and accept it. Estimates of survival are in weeks rather than months, and they are quite willing to relinquish the possibility of another remission. They do not believe in miracles. Indeed, their condition may be so pitiful as to command the sympathy of family, friends and caregivers alike. The only desire is to shorten the process of dying and terminate the suffering.

Charles F. McKhann, *Is There a Role for Physician-Assisted Suicide in Cancer? Yes*, Important Advances in Oncology, 267, 269 (1996).

2. Recognition of the Right to Receive Physician Assistance Will Serve to Ensure Safety and Curtail Abuse

As was true with abortion in the years before this Court's decision in *Roe v. Wade*, the continued criminalization of physician assisted suicide has not stopped many physicians from aiding competent patients to end their suffering. *See* Jody B. Gabel, *Release From Terminal Suffering? The Impact of AIDS on*

Medically Assisted Suicide Legislation, 22 Fla. St. U.L. Rev. 369, 372-73 (1994); L. Slome, J. Moulton, C. Huffine et al., Physicians' attitudes toward assisted suicide in AIDS, 5 J. AIDS 712-18 (1992); Dick Lehr, *Death & the Doctor's Hand, Increasingly, Secretly, Physicians Are Helping the Incurably Ill to Die*, Boston Globe, Apr. 25, 1993 at 1.

In the face of legal prohibitions on physician assistance, others are coming to the aid of the dying. One recent study surveyed 1139 critical care nurses in the United States, of which 71 percent practiced exclusively in intensive care units for adults. Of that group, 17 percent reported requests from patients or family members for euthanasia or assistance in suicide;[11] 16 percent of those asked, did so. An additional 4 percent stated they had hastened a terminally ill patient's death by pretending to provide life-sustaining treatment ordered by a physician. David Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-79 (May 23, 1996).

One California study of persons caring for loved ones with AIDS found more than 10 percent of these caregivers reported giving drugs to hasten their loved ones' death. M. Coode, L. Gourlay, L. Collette et al., *Dying of AIDS: The Role of Caregivers in Terminal Care and Hastened Death*, Center for AIDS Prevention Studies, University of California, San Francisco, Paper presented at the 10th International Conference on AIDS, Yokohama, Japan, August, 1994.

The ban on assisted suicide has simply ensured that persons lacking the requisite training will continue to intervene on behalf of those wishing to die. A desperate individual left to his or her own devices may likewise be forced to resort to whatever means are available to curtail suffering, such as "hanging, suffocation or shooting." Jeremy A. Sitcoff, *Death with Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide*, 29 J.

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[11] David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-75 (1996).

Marshall L. Rev. 677, 687 (1996). Without physician assistance, the consequences may be other than intended, potentially resulting in severe injury (e.g., coma, brain damage or increased agony). "Often, the person who has made a rational choice to die with dignity must accept his death in a totally undignified manner". *Id.*

3. People with Terminal Illnesses Should Not Be Compelled to Die in a Drug-Induced Semi-Conscious Haze

The typical treatment of people with terminal illnesses that cause great pain is to administer high levels of pain medication to the individual, which typically puts him or her in a semi-conscious state for an extended period of time. In administering this medication, the physician is fully aware that there is a significant probability of killing the patient. However, this is considered sound medical practice, while assisting an individual with the intent to help the individual end his or her life is a criminal act.

Individuals should not be forced to spend their final days in a drug-induced stupor to alleviate their pain. To many individuals, the prospect of leaving this world in such a state of prolonged semi-consciousness is a fate worse than death. In one study of eighteen patients with cancer, one patient with prostate cancer and bone metastases stated: "Who wants to suffer this kind of pain? The medication puts me to sleep. As soon as I wake up, there is the pain. If I can't live free of pain, I'm not living at all, simply existing." McKhann, *supra* at 268.

With the option of physician assisted suicide, terminally ill individuals may choose to remain fully conscious, recognizing that they may end their suffering permanently at any time. This option, therefore, allows them to spend their remaining days saying good-bye to their friends and relatives and putting their affairs in order. To them, and to most people, this dignified exit is far preferable to having their loved ones look on hopelessly as they slowly drift from drug-induced semi-consciousness to death.

4. Physician Assisted Suicide Allows People with Terminal Illnesses to Postpone Ending Their Lives Until a Later Phase of Their Illness

The recognition by people with terminal illnesses that they can end their suffering often gives them the will to continue to live. A strategy of many terminally ill individuals is to determine the point in the disease process when it would be unbearable to live and to decide to end their lives at that point. The control that this gives them over their lives often allows them to sustain a willingness to live. Many times, individuals reach the planned point and extend their self-imposed limit to a later stage of the disease. Often, they postpone the decision permanently, and die from the disease. Mary Evangelisto, *Death with Dignity: End-of-Life Issues for the HIV/AIDS Patient*, 34 J. Psychosoc. Nurs. 45, 46 (1996).

IV. CONCLUSIONS

Issues of autonomy and self-determination are at the heart of the struggle of people living with disabilities. They want to be able to control the decisions that affect their lives. Like the majority of Americans, they particularly do not want the state to deprive them of such control during their final days, if they have decided their suffering is intolerable. This decision must be made by the individual in consultation with his or her loved ones and personal physician. The state has no legitimate place interfering in this profoundly personal decision making process.

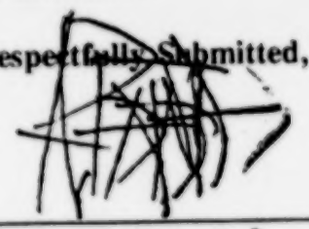
The right of terminally ill individuals to control their deaths is fundamental. There are few, if any, interests that are more basic to individual liberty, and few, if any, circumstances in which the state's interest is less. *Amici* do not want to be deprived of this right by the state simply because others, including others with disabilities, may not make this choice for themselves or because of concern over potential abuse. They do not want their disabilities to be used to justify the denial of this right to others. The interests of a dying person to control the remainder of his or her life far outweighs any state interests.

There is certainly no state interest sufficient to prohibit all people with terminal illnesses from obtaining compassionate assistance in dying from their physician.

Amici are committed to ensuring that the right to physician assisted suicide is applied fairly and appropriately. They believe that the vast majority of individuals who have available the option of physician assisted suicide will choose to live, comforted by the knowledge that the decision to continue to live is theirs and theirs alone. The enormous interest in this case by members of the disability community ensures that multitudes of disability rights advocates, including *Amici*, as well as other concerned individuals, will do everything they can to ensure this right is not abused and to encourage terminally ill individuals to choose to live.

The decision of the Ninth Circuit that people with terminal illnesses have a liberty right in ending their lives with the assistance of their physicians, and the decision of the Second Circuit that denial of this right constitutes a denial of the equal protection of the law, should be affirmed.

Respectfully Submitted,

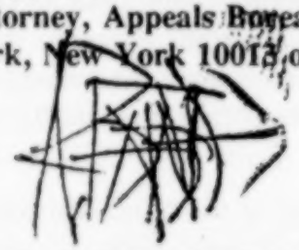


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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that true and correct copies of the foregoing were sent via U.S. mail to: William L. Williams, Deputy Senior Assistant Attorney General, Transportation and Public Construction Division, Office of the Attorney General, 905 Plum Street, Olympia, Washington 98504-0113; Barbara Billett, Solicitor General State of New York, Office of the Attorney General, The Capitol, Albany, New York 12224; and Marc F. Scholl, Assistant District Attorney, Appeals Bureau, One Hogan Place – Room 812, New York, New York 10013, on December 9, 1996.



Andrew I. Batavia

APPENDIX

PERSONAL STATEMENTS

OF

AMICI CURIAE

Personal Statement of Evan A. Davis

I am an attorney admitted to practice in the State of New York and a member of the Bar of this Court. I am a litigation partner with Cleary, Gottlieb, Steen and Hamilton in New York City. In 1949, at the age of five, I contracted polio and since then have gotten around with the help of braces, crutches and a wheelchair. For the last twenty years or so I have used the wheelchair almost exclusively. Because I received an excellent education and because my credentials are strong, this disability has not limited my practice.

I was asked to participate in this amicus brief by Professor Sylvia Law of New York University Law School. She told me that various groups representing persons with disabilities were filing amicus briefs in support of Petitioners urging that the interests of disabled people would be disserved by affirmance of the decisions below. As it happened I had just spent a good deal of time studying the legal issues now before this Court. With my knowledge of these issues in mind I agreed to participate because I thought the Court needed to be informed that if the issue before it is viewed narrowly, as it should be, affirmance would work absolutely no harm to the interests of people with disabilities.

My interest in this Court not being misled is two fold. The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

I also have an interest in this Court not being mislead because I believe it is uniquely the obligation of this Court under the Fourteenth Amendment to decide what is the proper scope of the citizen's right to be left alone by government in regard to seeking a dignified death. If this issue is left to the legislative process the result will likely be influenced by religious views whose sincerity I respect but which are contrary to my sincerely held religious views. Therefore I have a particularly strong interest in this Court making a sound decision on solely secular grounds based on accurate information.

Evan A. Davis

12/2/96

Date

Personal Statement of Hugh Gregory Gallagher

I am a writer and a historian. I am also a polio quadriplegic as a result of an attack of polio in 1952. For more than a decade, I have been studying and writing extensively on disability rights issues. I am particularly interested in the treatment that people with disabilities receive from the medical system. I am considered one of the foremost experts on the program authorized by Nazi Germany to "euthanize" over 200,000 of its citizens with disabilities.

The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. I do not believe that people with terminal illnesses should be denied the option of ending their lives in order to obtain relief from intolerable pain and suffering. This most personal of all decisions should rest between the person and his God.

In my book, By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich, I describe in detail how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living." The program was authorized by Hitler in 1939 and placed under the direction of his personal physician. Although the program was called "euthanasia," the vast majority of the people killed were not terminally ill or in great pain or even requesting death. The killings began slowly, but soon enough, entire wards were being provided "final medical treatment." The patients were given no choice over whether to live or die.

The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability.

In our generation, great strides have been made to welcome people with disabilities into society as equal members with equal rights. For the first time, people with disabilities have assumed control over their own lives, without fear of sterilization, internment, segregation and ostracism, and the denial to their rights to vote, hold property, enter legal contracts, and obtain public education, transportation and accommodation. Now they should no more be denied the right to obtain assistance in dying if they become terminally ill than should anyone else.

To my mind, the issue comes down to control -- control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set by their physicians with the concurrence of the state. This must never happen here.

In the United States today, we are debating whether an individual in the terminal stages of an illness should retain control over his/her Self and his/her personal concept of quality of life -- even to the point of death with dignity -- or whether such control should be circumscribed by the state.

In my own experience, it was this sense of control and the concomitant knowledge that I could end my life should the situation become unbearable, that kept me going through the extraordinary pain and suffering that accompanies acute polio. I will not turn over this control, or my personal decision to live or die, to the state. That decision is mine and mine alone.

Hugh Gregory Gallagher

Nov 28 1996

Date

Personal Statement of Barbara Swartz, Esq., In Support of Physician-Assisted Suicide

I have end-stage renal disease (ESRD) and have been considered legally disabled for the past twelve years. For eleven and a half years, I was a home hemo dialysis patient; six months ago, I had a successful kidney transplant. But I am more than a kidney patient. Professionally, I am a lawyer, a law professor and a lecturer in public health. During these past twelve years, I have been very active as a volunteer in my national kidney organization.

Throughout my career, I have been a fighter for and protector of human rights. I have worked for prisoners' rights, women's rights and patients' rights. A common theme running through these various areas is my strong commitment to the right of the individual to maintain her autonomy and dignity. In the area of patients' rights, I believe in the full and active participation of patients in our own health care decisions including end of life and death decisions. It is in making these profoundly difficult decisions that the right to individual autonomy becomes most meaningful. Competent patients already have the legal right to refuse treatment even if this decision leads to their death. In my mind, there is little legal difference between this right for a physician to help a person die with dignity, and the opportunity for a physician to prescribe medication which a competent person may choose to self-administer even though it too may lead to her death. In both cases, we are discussing the means used, either passive or proactive, to achieve the same end result. As a competent patient, I believe passionately in my right to maximum participation in one of the most intimate decisions that affects me: how I die.

I do not say that this is an uncomplicated issue and I understand that honorable people may disagree on what approach to take in cases of people wishing to die when they are in the end stages of a terminal illness. Before a physician consents to a patient's request for a lethal dose of medication, I would want to ensure that a patient is offered effective pain management and appropriate psychological assistance. Ideally, I would also like to believe that there has been an active and ongoing dialogue between the physician and the patient about this decision. But this is a matter of effective regulation rather than a strict prohibition of the practice. Ultimately, I believe that the final decision about whether to live or die must be left to the patient.

I have always been actively involved in decision making about my illness. From the onset of my kidney disease, I had to make the decision about whether to go on dialysis or not. I knew that a decision not to choose dialysis was a

decision to die. Every time I dialyzed, I made the decision to choose life over death. I also had to decide whether to put myself on the transplant list and then when a kidney was offered to me, whether to accept the offer. Each of these decisions is more comparable to a competent person's right to refuse treatment. However, I would hope that if I chose to end my life because of unbearable pain and suffering, and I needed help, I would be able to call upon my physician to assist me in dying with dignity. For me, the basic question is whose life and death is it anyway?

Barbara Swartz, Esq.
Barbara Swartz, Esq.

November 30, 1996

STATEMENT OF MICHAEL A. STEIN

I am a thirty-three year old individual who uses a wheelchair due to a childhood illness that brought about spastic paraparesis. Aside from this limitation on my mobility, I am otherwise in good physical condition and enjoy an active and healthy lifestyle.

Professionally, I teach a course on Physical Disability Law at New York University Law School while working towards completion of my Ph.D. studies in legal history at Cambridge University. Thereafter, I will return to full time law teaching and advocacy for the rights of individuals with disabilities.

In the past, I have tried to advance the status of disabled people through the publication of law review articles (See, e.g., Mommy Has a Blue Wheelchair: Recognizing the Parental Rights of People With Disabilities, 60 Brooklyn L. Rev. 1069 (1994); From Crippled to Disabled: The Legal Empowerment of Americans With Disabilities, 43 Emory L.J. 247 (1994)), editorials (See, e.g., Attitudinal Barriers to Hiring Attorneys with Disabilities, 17 Physical and Mental Disability L. Rev. 214 (1993); When Justice is Blind: Appointing Vision-Impaired Individuals to the Bench, 1 Minority L.J. 5 (1992)), service as President of the National Disabled Bar Association (1992-94), and direct lobbying of members of the United States Congress.

On a personal note, I am newly wed to a wonderful person who makes me enormously happy. In other words, I have every reason to be grateful for my existence and to want its indefinite continuation.

Nevertheless, I feel so strongly about allowing people with disabilities the option of assisted suicide, that I readily agreed to be named as party in this amicus brief. This is because, whether through illness or other circumstances, occasions arise that make some peoples' lives unbearably painful. Without the option of a facilitated passing, their existence becomes no more than an extended personal torture as they are sentenced to wait for a grim and demeaning demise. By honoring an opportunity of assistance, those people who so choose, may regain control of both their existence and their dignity.

I believe that whether an individual chooses to bring about her own demise is an intimately personal choice and should remain a private decision, protected from state regulation. The blanket prohibition against assistance in the statute at bar is invasive, eradicating a difficult decision which must be made by an individual in consultation with his conscience, family and friends.

The option of assisted suicide should be available for people who currently desire this course as well as for others, such as myself, who want a similar freedom to act in case of future circumstances.

10/29/96

Michael A. Stein

Personal Statement of Susan Webb

This statement declares my personal support of a terminally ill individual's right to die. I also support a terminally ill individual's right to die with assistance of another when it is assured that the individual has made his/her decision in writing and has made the decision after as many options for living as practicable have been made available to him/her. Under no circumstances must an individual be assisted in his/her suicide under coercion, especially by the individual who will be assisting.

Like many other persons with a disability, I have some concerns about this issue. Many persons with disabilities are relegated to institutions such as nursing homes where they feel trapped and without other options based on archaic, paternalistic systems. The only information they are given is often from persons who are not themselves disabled and who cannot fully understand the disability experience firsthand and that life with a disability can be full and rewarding.

As a disability advocate I am personally committed to working on legislation, regulations, etc. that would guarantee that individuals with disabilities have access to resources and information that might lead them to choose life instead of death. I am committed to ensuring that no one chooses death because he or she does not have adequate information with which to make an informed choice. However, once a terminally ill individual has allowed considerable time and thought, with a complete understanding of their options, the decision to end his/her life with or without assistance must be respected and implemented.

I am a person who has lived with a significant disability since 1974. As a disability advocate, executive director of an independent living center, elected board member of a national disability-rights organization and compassionate American, I make this statement from a recognized position of expertise and after much forethought. However, this statement is to be construed as a personal declaration and in no way reflects the opinions of any organization to which I belong.

Susan Webb

12-3-96

Date

(51) (52)

Nos. 96-110 and 95-1858

Supreme Court, U.S.
FILED
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BRIEF AMICUS CURIAE OF SURVIVING FAMILY MEMBERS IN SUPPORT OF PHYSICIAN-ASSISTED DYING

- IN SUPPORT OF RESPONDENTS -

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Solomon, A., A Death of One's Own, The New Yorker, May 22, 1995 4,23

I. STATEMENT OF AMICUS CURIAE.

The amicus curiae is composed of fifteen distinct individuals--not an organization, a religious group, or a group of politicians. The amicus consists of one family member of an individual who experienced the positive aspects of physician-assisted dying and fourteen family members of individuals who experienced unnecessarily painful, traumatic deaths in the absence of physician-assisted dying. They submit this Brief in support of Respondents.[1] The family members[2] are the voices of their deceased loved ones, describing for the Court the differing realities of what happens to families when a competent, terminally ill person is granted or forbidden the choice of a hastened death. The individual experiences present the Court with the emotional resonance of dying with and without physician assistance to hasten the process. In each case, the dying person desperately wanted to hasten death--some were successful with plastic bags, some chose guns, some died slowly but naturally, in agony and without dignity, and one died when and how he wanted, under medical care, peacefully, with loved ones present. The perspective of persons who have had recent experience with this issue is relevant and necessary to the Court's proper and full consideration.

Declarations of the fifteen family members are attached hereto as Appendices 1-15.[3] The group includes a woman whose husband, dying of lung cancer, obtained medication from his physician and was able to have a peaceful and gentle death--with his wife, daughter, nurse and trained Compassion In

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[1]The parties have consented to the filing of this Brief and the letters of consent are on file with the Clerk of this Court.

[2]The term "family member" includes spouses, children, parents, and partners involved in a close personal relationship.

[3]Originals of the declarations are either on file in the Ninth Circuit case below or in the office of the counsel of record herein.

Dying volunteers at his bedside (App. 1). In juxtaposition, the remainder of the group includes:

- a widow whose husband of 25 years was compelled to shoot himself in their front yard in order to end his debilitating pain (App. 2);

- a daughter whose mother was wasted by cancer to a mere 60 pounds before she swallowed morphine (App. 3);

- a widow who helped her husband prepare the sleeping pills he would take to avoid the devastating terminal stages of esophageal cancer (App. 4);

- a husband whose wife of 49 years had to die alone with a plastic bag over her head rather than face the unbearable pain caused by a heart condition (App. 5);

- a mother who struggled to medically assist her 26 year old daughter to die, because a doctor's help was not available (App. 6);

- the partner of a man who, dying of AIDS, withheld his own insulin to hasten his death, dying with convulsions, dementia, violent outbreaks, and a total loss of dignity (App. 7);

- a daughter whose family had to clean her father's splattered brains off the basement walls after he shot himself with his 12-gauge shotgun to avoid the excruciating pain caused by lung cancer (App. 8);

- a daughter whose father lay dying, diapered, moaning in pain and begging to die while the doctor refused morphine because it could kill him (App. 9);

- a widow devastated by watching her husband of 47 years live two months longer than he wished, slowly dying of cancer (App. 10);

- a man whose surrogate son failed in his suicide attempt and ended up in a coma (App. 11);

- a partner who was charged with murder and assisted suicide because he was present when his partner, dying of AIDS, took pills and sat in his car to ingest carbon monoxide (App. 12);

- a son who was criminally prosecuted for helping his 88 year old father, dying of cancer, hold a plastic bag over his head (App. 13);

- a man whose partner, dying of AIDS, destroyed his last few weeks of life agonizing about how to commit suicide (App. 14); and

- a daughter who had to leave her father to die alone so she would not be implicated in his death (App. 15).

The fifteen are among a significant number of Americans who have witnessed loved ones die in pain and agony, against their wishes and in an affront to their beliefs and personhood--denied the legal right to medical assistance to end unbearable suffering and hasten inevitable death.[4] They give

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[4]Various sources recount experiences of hundreds of Americans similar to the experiences of the fifteen representative family members. M. Battin, The Least Worst Death (1994); G. Burnell, Final Choices: To Live or to Die in an Age of Medical Technology (1993); C. Farnsworth, Vancouver AIDS Suicides Botched, N.Y. Times, June 14, 1994 at C12; S. Jamison, Final Acts of Love

their names and sacrifice their privacy and that of their family to preserve their liberty and the liberty of others who are terminally ill and wish to die with dignity. With the combined personal experiences of this group, the amicus has a profound interest in this litigation.[5]

II. SUMMARY OF ARGUMENT.

The amicus urges this Court to affirm the en banc decision of the Ninth Circuit Court of Appeals, Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996), and the decision of the Second Circuit Court of Appeals, Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) finding unconstitutional Washington and New York statutes which make it a crime for a physician to knowingly aid another person in committing suicide as applied to the care of a competent, terminally ill patient.

(1995); G. Kolata, AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure, N.Y. Times, June 14, 1994 at C1; S. Nuland, How We Die: Reflections on Life's Final Chapter (1994); T. Quill, Death and Dignity: Making Choices and Taking Charge (1993); T. Quill, A Midwife Through the Dying Process (1996); J. Rachels, The End of Life (1986); B. Rollin, Last Wish (1985); L. Shavelson, A Chosen Death: The Dying Confront Assisted Suicide (1995); P. Singer, Rethinking Life and Death (1994); A. Solomon, A Death of One's Own, The New Yorker, May 22, 1995 at 54.

[5]Statements to the Court similar to those filed herein are not without precedent. In Webster v. Reproductive Health Services, 492 U.S. 490, 106 L. Ed. 2d 410, 109 S. Ct. 3040 (1989), an amicus brief filed with and considered by this Court, entitled "Women Who Have Had Abortions, et al.," included declarations by numerous women who had experienced legal and illegal abortions. As in Webster, the declarations filed here contain relevant first-hand information by persons intimately familiar with the issues on appeal. It should be noted that Petitioner State of Washington's Brief cites newspaper accounts of stories of people dealing with this issue. Washington Petitioner's Br. at 16-17.

The experience of one of the fifteen survivors--recounting the positive aspects of having a physician and other medical personnel assist in a hastened death--demonstrates why the choice to seek physician assistance is a liberty interest protected by the Due Process Clause of the Fourteenth Amendment. This one experience evidences the profoundly personal, intimate, and important nature of this decision, central to personal dignity and autonomy.

The experiences of the remaining fourteen survivors exemplify how the state laws prohibiting physicians from prescribing medication to hasten death burden the liberty interest of competent, dying patients. The Ninth Circuit decision below correctly recognized that the extent of the burden on liberty was one of several relevant factors in determining whether the challenged law violates an individual's substantive due process rights. Compassion in Dying, 79 F.3d at 816. The individual experience of each of the fourteen surviving family members presents one or more of the following ways in which the current laws constitute an undue burden:

- The current laws result in untold pain, agony, and suffering for some dying patients who would prefer death; a slow, debilitating death is often accompanied by a profound loss of dignity and self-respect.

- The current laws cause some patients to choose a violent, often gruesome manner of hastening death; these suicides are generally committed alone, without family present.

- The current laws result in the failure of some attempts to hasten death, due to the absence of trained medical care--sometimes leaving the patient in worse condition than before the attempt.

- The current laws result in some family members feeling compelled to assist their loved ones to hasten

death, with concomitant fear and hiding, guilt, and occasional criminal investigation and prosecution.

- The current laws result in suffering, guilt, anger, and remorse for some surviving family members.

Additionally, to deny medical assistance at a time of such need is to deny some terminally ill people equal protection of the law under the Fourteenth Amendment. To permit physicians to remove life support systems or to refrain from taking life sustaining measures, thereby hastening death, provides those terminally ill patients with a choice to die with dignity, a choice denied other terminally ill patients who cannot obtain medical assistance to hasten death.

III. THE CONSTITUTION PROTECTS INTIMATE, PERSONAL, AND IMPORTANT DECISIONS INCLUDING THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR A TERMINALLY ILL, COMPETENT ADULT.

A competent, terminally ill patient has a liberty interest in determining the time and manner of his or her death. Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992); Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 281 (1990). In Casey, this Court recognized that certain matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." Casey, 505 U.S. at 851. As the Ninth Circuit court below added:

> A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final

> period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying, 79 F.3d at 814.

For Richard Lau, the decision he made to choose physician assistance in dying during the last weeks of his life exemplifies the intimate, personal, and important nature of this decision.[6] For Roberta Lau, his widow, his decision positively affected the "enduring memory" she had of her husband's demise. Her statement reflects the dignity and peace that can accompany a physician-assisted death:[7]

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[6]Providing the means and ability to hasten death for the terminally ill can also provide a feeling of control over one's life and peace of mind, even if the physician prescribed medication is never used. Richard Posner, Age and Old Age 243-53 (1995). Moreover, having a physician involved in this important decision-making process can sometimes reverse a patient's decision to end his or her life. Under current state laws patients "... cannot make use of the professional help their doctors, psychologists, psychiatrists, or other counselors have to offer in exploring choices of suicide and which might provide them with very real help. As a result, some older, disabled, or dying persons commit suicide when they do not really wish to do so..." Margaret Pabst Battin, The Least Worst Death 272 (1994). "Our public policy should encourage doctors to be creative and openly responsive, rather than fearful and secretive, when patients are faced with a bad death." Timothy E. Quill, M.D., A Midwife Through the Dying Process 26 (1996).

[7]See Peter Singer, Rethinking Life and Death 148 (1994) for how a planned, hastened death in the Netherlands, where physician-assisted dying for the competent terminally ill is legal, can be even more dignified, since it is legal. The author describes the planned death of Carla: "She had the best possible medical attention, right up to the moment of death. Her family could be with her, and even her priest. Nothing had to be furtive. There was no need to fear failure. No-one had to lie awake afterwards wondering if the police would knock."

My husband of 42 years, Richard A. Lau, died on October 12, 1995. My husband's desire and intent always was to find the means to hasten his own death when his physical condition was no longer bearable. He died after taking a sufficient supply of drugs prescribed by a physician that took a long search and numerous inquiries to locate.
Richard had been battling lung cancer for two years before he died. ...

Approximately three weeks prior to Richard's death, he was examined by an independent physician, not his treating physician. This physician verified that Richard was mentally competent, not depressed, and fully aware of the consequence of his decisions. The physician determined that Richard's condition was terminal and that he had no more than one to two months to live. ...

Richard decided that he wished to die on Thursday, October 12, 1995. A nurse, my adult daughter, and two trained volunteers from Compassion in Dying were present with him. Everyone checked with Richard to see if he had changed his decision. He was clear and adamant in his determination to proceed.

Richard was helped with personal care matters, smoked a cigarette and visited with those present. He then personally took the medications. He was very relaxed and at peace and thankfully welcomed his liberation. He always worried so much about finding this assistance and it was a blessing when we did. We did not believe in prolonging suffering needlessly.

At the end, his death at home was very calm and peaceful. I supported him all the way.

I believe all terminal and suffering persons should be able to legally seek supervised and regulated assistance

in dying, if that is their wish. Prolonging suffering needlessly is inhumane.

Appendix 1.

IV. DENIAL OF THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL ADULT PATIENTS IMPERMISSIBLY INFRINGES UPON THE LIBERTY INTEREST OF THE PATIENTS.

State regulations may not impose an undue burden on recognized liberty interests. Casey, 505 U.S. at 873. The majority of the declarations show that the Washington and New York statutes, in prohibiting physicians from prescribing medication to end life, do impose an undue burden and thereby impermissibly infringe upon the liberty interests of competent, terminally ill patients.

A. Terminally Ill Patients Denied the Choice of Physician- Assisted Dying May Be Forced to Endure Horrific Pain and Suffering and Loss of Dignity.

All of the family members witnessed the intense suffering of their loved ones in the weeks or months before their inevitable deaths. The statements dispel the myth that pills can always control all pain.[8] Moreover, doctors sometimes refused to prescribe sufficient pain-killing medication because of their

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[8]Despite new advances in pain treatment, an "irreducible core of patients are trapped in physical agony (if they are awake)." Kreimer, 44 Am. U.L. Rev. at 831, n.93. Pain cannot be controlled in 5% to 10% of cases. The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 40, n.18 (1994). Often, controlling pain sacrifices the patient's consciousness, which "is tantamount to causing death; the patient has no further conscious experience and thus can achieve no goods, experience no significant communication, satisfy no goals." M.P. Battin, supra, at 105.

fear that it would be used to hasten death.[9] Thus, laws barring physician-assisted dying contribute to suffering by causing some doctors to withhold medication. Additionally, as family members attest, a slow, deteriorating death often leads to loss of dignity and self-respect for the dying person.[10]

Dorothy Hoogstraat witnessed her husband's horrible suffering, which medication could not ease:

> My husband, Emerson E. Hoogstraat, a retired Professor of Finance, from Portland State University, died on March 25, 1995 of prostate cancer that had spread to the bones. . . .
>
> He was relatively comfortable until June of 1994 when a series of new problems developed. Following further diagnostic procedures it was ascertained that the cancer had spread to his ribs, spine and right femur. He was in considerable pain when walking, sitting or lying in bed. ... His ribs gradually broke, and as he said to me many times, he could feel the broken edges of the bones rub together as he would sit or attempt to arise from the bed. He was in unbearable pain. He was an extremely intelligent, courageous and dignified man and he did not wish to suffer unbearable pain when there was no hope of recovery from this condition. He would very much like to have gone to sleep in his own bed and not had to suffer further. He felt that it was his right to say when he had suffered enough. He "lived" at least two months after he would have preferred not to. The physicians and Hospice people were constantly changing medications and attempting to make him as comfortable as possible-- which in his condition was an

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[9]T. Quill, supra, at 197 ("Often, doctors undermedicate dying patients' pain or shortness of breath because of the legal risks [both exaggerated and real] associated with overmedicating.").

[10]See Sherwin B. Nuland, How We Die, Reflections on Life's Final Chapter 142 (1995).

> impossibility. It was a twenty-four hour a day caregiving situation and he still suffered unbearably. He remained at home until his death. ...
>
> We had been married for forty-seven years and shared a lifetime together, and truly, watching him suffer and being unable to do anything for him that would relieve his pain was for me devastating.
>
> I do not believe that God intended for people to suffer in this manner. We are more compassionate with our pets than we are with our dearly loved family members.
>
> Appendix 10.

Gail Bereny speaks of the unwillingness of her father's physician to prescribe adequate pain medication:

> Several years ago, my 80 year old father was diagnosed as having terminal abdominal cancer. He went to his doctor with two requests, (1) not to prolong things, and, (2) to keep him as pain free as possible. His doctor agreed. However when time came, the doctor did neither. And so my father, to whom dignity was very important, lay dying, diapered, moaning in pain, begging to die. I called the doctor's office, crying, begging him to relieve Dad's pain. He refused, saying morphine could kill him. . . .
>
> I felt very guilty then, and feel guilty now, about Dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness. He had been a very good father.
>
> Appendix 9.

B. Terminally Ill Patients Denied the Option of Physician-Assisted Dying Are Sometimes Forced to Experience a Violent, Lonely, at Times Gruesome Death.

In a number of cases, the terminally ill chose violent deaths rather than continued suffering.[11] They died completely alone, without the comfort of their families. Their violent deaths often resulted in gruesome and tragic consequences for family left to deal with the remains.

Tania Bloom describes the brutal experience of her elderly father's suicide:

> In 1989, my father was dying of lung cancer and was in excruciating pain. His doctor would not provide pain medication other than Tylenol saying that to do so "would not be medically advisable." Father remained at home and in spite of being hooked up to oxygen, he struggled to breathe. We had access to morphine and hinted to him that we could get it for him if he wanted it. However, he refused because he knew it was illegal to assist in a suicide.
>
> When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12-gauge shotgun. He was 84. . . .
>
> This was a brutal and awful experience for my children and for me. I felt a great deal of loss, anger, and remorse about a system that would not allow my father to die gracefully and with dignity.

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[11]The Ninth Circuit court below cites the example of how one of the patients of physician plaintiff Dr. Harold Glucksberg ended his life by jumping from a bridge in Seattle after Dr. Glucksberg could not legally prescribe medication to hasten his patient's AIDS-related dying. Compassion in Dying, 79 F.3d at 834.

> My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.
>
> Physician assisted suicide should be a rational choice and a reassurance for people. Physician assisted suicide can have safeguards and planning so that it wouldn't be an impulsive, irrational act and one of unnecessary violence such as that of my Dad's.
>
> Appendix 6.

Patsy McGeorge's husband also felt compelled to end his life with a gun:

> My husband of twenty-five years, Emanuel J. ("Mac") McGeorge, had terminal cancer involving the spine, lungs and lymphatic system. But terminal cancer is cited only as "other significant condition" to his cause of death on the death certificate. The certificate reads: "Death due to or as a consequence of: Massive trauma to head -- self-inflected [sic] gun shot wound-shotgun." ...
>
> During late spring of 1995, he broached the subject of suicide. It was not the first time suicide had been mentioned, but this time he was quite serious. He told me of his great concern for becoming incapacitated, or so ill that he would either be hospitalized or would not, for some other reason, be able to govern his own destiny. He was relieved to have my assurance that he would never be hospitalized against his wishes, and that I would respect and support any decision he made about ending his own life. Mac also brought up the possibility of assisted suicide with his doctor, but while his doctor was understanding, he was not supportive.
>
> By October, Mac had already surpassed his predicted nine-month life expectancy, but the cancer was taking its toll. He had gone from a man of 190 pounds of muscle, exceptional strength, and superior stamina to a "145 pound weakling." ... By January of 1996, he was able to eat very little; his weight loss was becoming extreme. The principal spinal tumor had grown so large that he

referred to his appearance as that of the "Hunchback of Notre Dame." He could only sleep on his side, and despite 800 mg. of morphine a day and Roxicet every two hours, his pain was so extreme that sleep came only in short intervals. He could lie down for only an hour or two at a time. He struggled through January, but by the first of February, he couldn't take much more. We were referred to Hospice, an outstanding group that does a great deal to ease the pain and suffering of the terminally ill, but regrettably cannot assist in ending that suffering. With a subcutaneous pump to assure a continuous morphine flow and additional medication, Hospice nurses were able to provide Mac his first full night's sleep in months. But Mac did not want to be a drugged vegetable. Following an almost 24 hour drugged stupor, he decided that was not the answer.

On the morning of February 9, 1996, he had made up his mind. ... After a brief and very personal conversation, he gave me the note he had carried for months, attesting to the fact that his decision was his own; kissed me goodbye; went into the front yard, put a shotgun in his mouth and pulled the trigger. Since a peaceful death was not available, this was his way to insure death with the dignity he valued so highly. Two months ago I was emotionally wrenched by finding a portion of his upper dental plate 50 feet from the site of his death -- a testament to the violent alternative he was forced to choose.

Mac was not depressed -- the overwhelming pain or alternative of a drug stupor were simply unacceptable to him. Mac honestly believed he, with my support, had the right and the responsibility to control his own destiny.

To say that I miss him would be the understatement of the century. But I esteem his courage, his conviction, and his integrity. I am thankful that he loved me enough to share his most personal emotions. I wish I could have been with him at the end, but he said no, "it will be messy." Appendix 2.

Jinny Tesik attests to the loneliness involved when family members choose suicide, not wanting to legally implicate those left behind:

> Unable to live alone due to his own battle with emphysema, Dad lived with me for the last two years of his life. He was adamant that he would not let his disease control him the way his wife's lung cancer controlled her. He intended to take his life while he still had his dignity, self-respect, and, above all, was still in control of his life. He made me promise that I would honor his choice. He threatened that if the means for him to take control of his death were not available, he would kill himself with a kitchen knife.
>
> The emphysema progressed. Dad was tethered to 30 feet of oxygen tubing; he seldom left his bedroom. Breathing became more difficult and eating became a problem. His physician was totally opposed to providing the help Dad requested. One morning, he reminded me of my promise to help him. He discussed his plan rationally, non-emotionally. He was ready to die and needed my support. We raided the medicine cabinet and I was sent out to buy some vodka. We spent the day together. Toward evening, he asked me to leave the house and not return until very late. He did not want me to be implicated in any way in his suicide. Saying goodbye to my dad was one of the saddest times of my life. And I had to go through that long night alone for I, in turn, could not implicate anyone else in the knowledge of my dad's death. He died in 1990 at the age of 76.

Appendix 15.

C. Terminally Ill Patients Denied the Option of Physician-Assisted Dying May Be Forced to Rely on Family Members to Assist in Hastening Death.

Some of the fifteen deceased could or would not violently end their life with a bullet to the head. Nevertheless, they were determined to control the timing of their death and felt compelled to rely on the assistance of family.[12] This alternative brings other problems. The dying person has to worry about legal implications for survivors. Family members must engage in a conspiracy of silence to hide their involvement--at a time when they are grieving.[13] For some, criminal investigation and even prosecution for assisted suicide does result. Clearly, having untrained, emotionally involved family members assist in hastening death without medical supervision is not the most desirable alternative.[14]

Kay Beck, a retired school counselor, describes her involvement in her husband's death:

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[12]The Ninth Circuit court below recognized that an additional burden was that "[T]hose who decline to assist may always wonder whether they should have tried to save their parent or mate from enduring, unnecessary and protracted agony." Compassion in Dying, 79 F.3d at 836.

[13]Stephen Jamison, Ph.D., Final Acts of Love: Families, Friends, and Assisted Dying 169 (1995) ("Until the laws change, secrecy will remain one of the most dominant features of assisted death.").

[14]Ibid. 5 ("This illegal assistance ... goes on without guidelines, safeguards, psychological counseling or evaluations, required consultation with specialists, referrals to hospice, or even mandatory discussion of alternatives."). Moreover, sometimes family members are not those assisting. "In the absence of legally available aid from physicians, abuses are occurring at the hands of unregulated freelance euthanasists, illegal suppliers meeting an otherwise unmet demand." Lonny Shavelson, A Chosen Death: The Dying Confront Assisted Suicide 67 (1995).

> On Nov. 11, 1991, I helped my husband, Jack, end his life. In the terminal stages of esophogical [sic] cancer, he faced paralysis within days. Paralysis for Jack was a fate worse than death. Always an extremely active, rational, self reliant, responsible person, he fought for his life as long as he could. When it became apparent the end was near our plan was that he would end his life with sleeping pills, as difficult and isolating as that proved to be. On the 10th of November he wrote his suicide note and we prepared the drugs. Jack died the next morning of a drug overdose in the room he loved with me but not our children by his side.
>
> The effect of the law against assisted suicide is to create a conspiracy of silence around the terminally ill at their time of ultimate loss and greatest need. It causes isolation, anguish, desperate acts, and prolonged suffering. I do not wish to go to jail but who is to speak for those who have died alone or those who fear prosecution if I do not.
>
> To classify me as a criminal because I refused to leave my husband's side at his time of greatest loss I find unconscionable. The law against assisted suicide is a travesty, a violation of my rights as an adult. The judicial system must find this law unconstitutional or be prepared to put people like me in jail.
>
> Appendix 4.

Patty Rosen had the unthinkable task of helping her daughter hasten her death:

> The person dying was my 25 year old daughter and she asked me to help her die, and I did. I didn't have to assist Jody's death. Jody was still capable of giving herself a fatal dose of medication. But Jody didn't want to die alone. She wanted me there with her, to comfort her, and to make sure she died.
>
> Bone cancer. Invasive bone cancer. Literally, from her head to her toes she was filled with bone cancer. ... Bedridden, Jody was trapped in a body that barely

worked. She slept, medicated, 23 out of 24 hours. Even then her face reflected the pain she was constantly enduring. She was also losing her sight, tolerated painful procedures for total bowel obstruction, and shuddered with pain if anyone so much as touched her skin because of the tumors that were barely under the surface. And, her bones. Bones that were slowly "burning" ("it feels like hot molten lava inside of me") away with cancer. Daily she let me feel her despair. Daily, her eyes dulled by medication, the question would come: "Mom, how long can you watch me suffer?" "Mom, please help me." ...

... She was dying, she knew it, and she was ready to die now. Rational, calm, ready. However, it was illegal for me to assist and she knew it. "I should be able to talk with my doctor and plan this, not ask my Mom" "Mom, what if you go to prison?" "What will happen to you?" Worry made her small face with the sunken eyes of the near death take on an incredibly distressed look. Wasn't it enough that she was dying without having to worry about me? ...

Finally, four months after her request, choking on my tears, I said, "Jody, I'm ready." A look of relief came over her face. She was, in fact, almost giddy with relief. Quietly, softly she said, "Oh Mom, thank you. This is one of the happiest days for me. I don't have to wake up in this body again." ...

And then it was time. Jody calmly swallowed everything I could give her, took a few sips of water, kissed me, "See you later Mom," closed her eyes and went to sleep. I went into a pure panic. What if I failed? What if she regained consciousness? She would be even worse off. But more than that, I would have failed her. I began giving her all the I.V. medications I could pump into her stilled body. I moaned, sobbed, prayed, and kept pushing the drugs. I was as desperate as I have ever been. ...

Ten hours after we had started the process came the silence. She had finally stopped breathing. The year

and a half of pain, suffering, rage, and hopelessness had ended. I climbed into her bed, gathered her still body into my arms, finally able to hold her without hurting her. Stroking her hair, rocking her gently, I surrendered to my grief. A brave and wise young woman, Jody Lynn Grape, age 26, died October 30th, 1986, at 1:30 p.m.

I have never felt guilt or remorse for assisting Jody's passing. It was the ultimate act of love a mother could do for her suffering, dying child. I am grateful she trusted me enough to ask, made me feel her anguish, and included me in her dying. ...

Appendix 6.

Elvin Sinnard describes his wife's death and her worry about Elvin's involvement, even as she was on the brink of death:

Sara and I were married for 49 years. She suffered from a very painful heart condition the last eleven years of her life. Two open heart surgeries, several trips across the United States to specialty clinics, and very competent care from her cardiologist failed to relieve the debilitating pain. Finally life became unbearable. She could not even talk to me, her children, or her friends for five minutes without triggering the terrible pain. She wanted to die but we did not know how to do it. We could not ask her doctors since one practiced in a Catholic hospital and the other had a national reputation that would have been destroyed had he broken the law to help her.

She feared over-the-counter pills, hearing of all the cases where the person woke up a vegetable. Carbon monoxide was out since she wanted the dignity of dying in her own bed, surrounded by the things she loved. We finally learned of the plastic bag method. On the day of her decision, I was with her up to the point of placing the bag over her head and she said, "Elvin, you must

now go to the office because you cannot be implicated in this."

She had to die alone. I was denied my right to be with her when she died. This is not right.

I was taken to the police headquarters and interrogated for two hours attempting to establish a direct action on my part to the suicide. The detectives were polite and seemed sympathetic but they said, "Even though we might agree with your action, we would have to recommend indictment if we could establish a direct action on your part to the suicide. It's the law."

And, this is not right. My act was a loving act, not a criminal act.

A person has the right to control the conditions of their death as much as they have the right to control the conditions of their living.

Appendix 2.

William Meyer details his prosecution for helping his 88 year old father end his life:

> In 1991, my father, William F. Meyer Jr., who was 88 years old and had experienced five cancer operations, was in rapidly failing health. The cancer that had begun in his colon had spread to his lungs. He was losing weight and was being eaten away. His doctor said he only had a few months to live. ...
>
> After my father and I met with my father's doctor of 25 years, my father decided he would use the procedure featured in the book Final Exit, taking 12 sleeping pills and placing a plastic bag over his head.
>
> My father's first attempt at this action failed when his reflex action, which comes from the feeling of suffocating, caused him to pull off the plastic bag. When I returned to my father's home the next morning, he was awake and distressed that he was still alive.
>
> My father consulted with his doctor and was advised that I could hold my father's hands so the reflex action

> would not remove the plastic bag. My father and I followed this procedure and he was able to end his life.
>
> Since one of my father's last requests was that I tell his story, I joined the Hemlock Society and became a vocal spokesman for death with dignity. In the summer of 1994, I was interviewed for a story by Connecticut Magazine. After the story, I was arrested and charged by the police with second degree manslaughter. If convicted, I faced ten years in prison.
>
> At a hearing in December, 1994, before a Superior Court judge in Hartford, Connecticut, two ministers and several friends spoke on my behalf. Numerous people, including eleven ministers and eighteen doctors, wrote to the judge to support me. Even though the District Attorney pleaded that my case go to trial, the judge stated that although I had broken the law, I was following my father's wishes, and the judge considered me an outstanding citizen. I was given two years "accelerated rehabilitation" (after two years, all charges are dropped, with no record)....

Appendix 13.

Keith Green describes the horror of being charged with murder and assisted suicide after his long term partner died:

> I was arrested on December 4, 1995 in West Los Angeles after my lover of eight years committed suicide. Within hours of the arrest, I was charged with murder under California Penal Code section 187 and felony assisted suicide under California Penal Code section 401.
>
> ...
>
> In 1991, my lover tested positive for the human immunodeficiency virus ("HIV") and was diagnosed with full blown AIDS in early 1994. He was in the advanced final stages of the disease at the time of his demise. With his immune system entirely compromised he suffered from a panoply of debilitating diseases which were incurable....

On Monday, December 4, 1995, he told me that this would be our last morning together. He went into the bathroom where he remained for a considerable period of time. I learned afterwards that he had been taking a large and lethal quantity of chlorohydrate [sic] and seconal. Because his prior attempt at suicide by pills had failed, he had planned to use carbon monoxide as a back up.

After a tearful goodbye, he went to the garage where he had set up his car with tubing so as to facilitate the ingestion of carbon monoxide. Once seated in the driver's side of his car, he told me that it was time for me to leave....

I returned to our home within five to ten minutes of leaving. I went to the garage which was then filled with smoke and stayed with him in the car ...

After having been prosecuted for a felony for six months, the charges were finally dismissed on June 4, 1996. Though released on my own recognizance within a few days of having been arrested, the terms and conditions of my release precluded me from being at his funeral in his home town of Longview, Texas as I was not allowed to leave California....

In the end, the charges that were filed against me were the last thing that he would have ever wanted to happen.

Appendix 12.

D. <u>Terminally Ill Patients Denied the Option of Physician-Assisted Dying Sometimes Fail in Their Attempts to Hasten Death, with Tragic Results</u>.

Perhaps the worst result for a terminally ill competent adult who attempts suicide--worse than a violent suicide, or a lonely suicide, or a suicide implicating family members--is a suicide that fails, leaving the patient worse off than before. The denial of medical assistance inevitably increases the chance of a botched hastened death. Patients cannot know the type or dosage of medication to take or how to control nausea and

regurgitation accompanying the ingestion of lethal medication.[15] As the Ninth Circuit decision stated, "Miscalculation can be tragic."[16] The consequence can be brain damage or a coma.[17]

For Gösta Pearson, his surrogate son, dying of AIDS, failed in his attempt to hasten death which brought tragic consequences.

> On June 20, 1991, Hugo told me that he had decided to take his own life with some pills he had stockpiled. He told me I did not have to stay with him, but I wanted to be by his side. He prepared two glasses of

---

[15]L. Shavelson, <u>supra</u>, at 126 ("From safer sleeping pills to air bags in cars, science has made killing yourself without professional help a tremendously difficult task--and a mission fraught with the potential for ghastly errors.")

[16]<u>Compassion in Dying</u>, 79 F.3d at 832. Additionally, the Second Circuit quoted from one of the declarants in that case, <u>Quill v. Vacco</u>, 80 F.3d at 721:

> It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice.... Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

[17]<u>See</u> C. Farnsworth, <u>Vancouver AIDS Suicides Botched</u>, N.Y. Times, June 14, 1994, at C12 (of 34 assisted suicides studied in Vancouver, B.C. [which, similar to the U.S., bans physician assisted suicide], half were "botched, increasing suffering when the aim was to alleviate it."); Andrew Solomon, <u>A Death of One's Own</u>, The New Yorker, May 22, 1995, at 57 ("I heard of suicides as gruelling as the diseases they were meant to terminate. In some cases, irreplaceable pills were regurgitated. "My husband had to just eat his vomit," one woman said. "He was that determined. But then he threw up again. We waited about an hour; then he downed it all again and I put a plastic bag over his head so he would suffocate before he got sick, and he finally died. He'd been through so much, and that whole disgusting, humiliating business was the living end.").

medication and told me he was going to drink one glass and then follow with the other. He then drank all of one of the glasses. He then told me that "that didn't taste very good--will you get me a spoon of pudding from the kitchen". I did and he said "that's better." Then he reached for the second glass and passed out before taking the second glass of medication.

Hugo was in a coma for the next several days. I immediately called his physician, who came and examined him. Hugo remained in his home, receiving no food or hydration. Medical personnel told me that Hugo could hear us, even though he was not responding to us.

This was the worst seven days of my life. It was miserable for me, for Hugo, and for others to see his desired death stretched out for so long. I slept in his apartment during that week in order to be close to him.

If Hugo had been able to have a physician assist him in his dying, he could have died when and how he wanted, with dignity and without further complications and problems.

A program should be able to be developed so that people don't make the same bungling mistakes Hugo did. It is important for people in Hugo's situation to have the freedom of choice to end their life, without fear and without complications which make their dying process a nightmare.

Appendix 11.

V. DENIAL OF THE OPTION OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL PATIENTS HAS DEVASTATING CONSEQUENCES FOR SURVIVING FAMILY MEMBERS.

The states and other amici assert an interest in protecting from suicide the family members and loved ones of the

terminally ill.[18] However, as the Ninth Circuit court below observed, ". . . witnessing a loved one suffer a slow and agonizing death as a result of state compulsion is more likely to harm than further the interests of the innocent third parties." Compassion in Dying, 79 F.3d at 827.

The family members express extreme sadness, anger, and guilt over their loved ones' loss of dignity and loss of control over their own lives, resulting from laws prohibiting physician assistance in dying. Others decry a cruel legal system which legislates against the abstract notion of "suicide" rather than addressing the reality of the pain, suffering, and loss of personal autonomy and dignity of terminally ill, competent patients. This law leaves family members angry and frustrated that they are unable to obtain comfort for the loved one at his or her time of greatest need.

> I felt very guilty then, and feel guilty now, about dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness....
>
> Declaration of Gail Bereny (App. 9).

> It was a very lonely death. That's the one thing I will never get over. My mother came from out-of-state to be with me for a period of time as she was concerned for my emotional health. I was in therapy for six months.
>
> Declaration of Steve Knipp (App. 14).

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[18] See Compassion in Dying, 79 F.3d at 816, for discussion of State of Washington's arguments in this regard; also, see Amicus Curiae Brief of Nat'l Right to Life Committee, Inc., p. 26, which argues that children "may be more profoundly affected by suicide than by other cases leading to the death of a parent." This is undoubtedly true for ordinary suicides, but the statement hardly applies to suffering parents at the end of their lives.

> My mother's terminal illness was awful for me because I was very close to her. I had nightmares for weeks prior to her death. She was desperate, and in spite of my being a nurse, I felt helpless....
>
> Declaration of Leanne Gallison (App. 3).

The Ninth Circuit decision voiced "serious doubts that the terms 'suicide' and 'assisted suicide' are appropriate legal descriptions of the specific conduct at issue here." Compassion in Dying, 79 F.3d at 802. For this reason, we frequently use in this brief the term "physician-assisted dying" or "hastened death" rather than "suicide." Jinny Tesik, who supported the controlled dying of her 76-year-old father, suffering from terminal emphysema, compares her father's act with other suicides:

> My 39 year old husband committed suicide violently ten years ago by shooting himself in the head. That is the kind of suicide that leaves the legacy of guilt, anger, and unanswered questions. That kind of suicide devastates and destroys those left behind.
>
> After 12 years of working in hospice and as a grief counselor, I have heard far too many cases of others like my father who chose to be in control of their deaths. For those who choose their own death in their own time, let it be peaceful, loving and legal, not shattered by violence and shame.
>
> Appendix 15.

VI. THERE IS NO MEANINGFUL DISTINCTION FOR THE PATIENTS AND SURVIVING FAMILY MEMBERS BETWEEN A PHYSICIAN'S ASSISTANCE IN HASTENING DEATH AND A PHYSICIAN'S WITHDRAWAL OF LIFE SUPPORT.

A. The Deceased Loved Ones of the Amicus Were Dying of Terminal Illnesses and Suffering in the Same Way that Terminally Ill People with Life Support Measures Suffer.

The experiences of the amicus demonstrate that the distinction in the laws between withdrawing or refusing life support measures, a form of medical intervention, and choosing other forms of physician assistance to hasten the death of a terminally ill patient is meaningless for both the patient and the family. The patients who seek physician assistance to prescribe medication and those who seek physician assistance for withdrawal of life-sustaining treatment to hasten death are similarly situated. In both cases, the patients are facing an inevitable death caused by a fatal disease and are suffering, often unbearably.

The patients described by the fifteen declarants all suffered from diseases for which "life support," such as a ventilator or respirator, was not at issue. But they suffered as much as patients on life support, they knew they were dying, and they had exhausted all efforts to save themselves. Like those patients who make the choice to accept and hasten their inevitable deaths by refusing or withdrawing life support, they too wanted to end their suffering. Because of state statutes, they were denied the option to end their suffering with dignity and the comfort of their families.

B. <u>The Legislatures' Distinctions Between the Refusal or Withdrawal of Life Support to Hasten Death and the Acceptance of Other Forms of Physicians' Assistance to Hasten Death is Not Rational</u>.

The distinction in the law between withdrawal of life support and physician-assisted suicide makes no sense to those who are suffering while dying or to the families and loved ones who watch them suffer. It is not legally sufficient to say that because the state legislatures treat these actions as different, that they are in fact different. The Second Circuit accurately concluded that the withdrawal or refusal of life support <u>is</u> a form of assisted hastening of death and the two classes of patients should be treated equally. The Court explained:

> Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

<u>Quill v. Vacco</u>, 80 F.3d at 729.

The irrational nature of the distinction between the two classes of people is demonstrated by the drastic actions patients sometimes take to "legally" end their suffering. Jeff Halsey explains his partner Danial Danzer's struggle with AIDS:

> My partner Danial Danzer's biggest fear was that of losing his mind. He wanted to die before he lost his mind.
>
> Danial had reached the final stages of AIDS. He sought help with his problems from the medical community but didn't receive any. So when he felt his mind was leaving him, he opted for a unique solution to

> his problem, that being withholding his insulin and letting himself die of insulin stock. It was a very long five days of convulsions, dementia, violent outbreaks, and a total loss of self-dignity.
>
> I feel that had there been a way for him to end his life peacefully, that he would have opted to do so. Danial was lucky in that he had a way to deliver himself--by withholding his insulin. Most people are not that lucky. Most people must suffer even more than Danial suffered.

Appendix 7.

It is ironic that Danzer could legally withhold medication, such as insulin, but could not legally have a more painless way to hasten his death and maintain his dignity. Under Petitioners' rationale, Danzer's death was not legally "suicide" because the death was "unintentional," "inactive," and "natural," since Danzer died from diabetes and insulin shock. Washington Petitioners' Br. at 31 and New York Petitioners' Br. at 15-19. Clearly, Danzer's death was intended and he very actively sought death. How "natural" is it to die of convulsions and dementia? Similarly, how "natural" is death by starvation and dehydration, or an induced coma, both legal in Washington and New York states? The Second Circuit concluded these deaths are no more "natural" than a doctor prescribing medication to hasten death. <u>Quill</u>, 80 F.3d at 729.

VII. CONCLUSION

As the experiences of the fifteen show, many people are determined to control the dying process when faced with a debilitating terminal illness. This Court cannot stop the terminally ill from hastening their deaths--it does happen and will continue to happen as long as human beings have free

will.[19] The decision for this Court is how hastened dying for the adult terminally ill should occur: Will it be acts of violence taken alone? Will it be untrained family members compelled to assist in secrecy and fear? Or will it be medically-trained personnel evaluating and assisting, in the open, according to legal guidelines? Amicus urges the Court to recognize, as the Second and en banc Ninth Circuit Courts did, that legal guidelines can be established so that the state can protect its legitimate interests without substantially infringing upon the constitutional rights of those competent, terminally ill adults who choose to end their suffering and hasten death.

Respectfully submitted,

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*Counsel of Record

December 5, 1996.

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[19]T. Quill, supra, at 199 ("Doctors, patients, and their families are engaged in negotiated deaths every day in every community in the United States."). With AIDS, the number of end-of-life suicides has increased dramatically. G. Kolata, AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure, N.Y. Times, June 14, 1994, at C1.

PERSONAL DECLARATION OF ROBERTA LAU

My name is Roberta Lau. My address is 9586 Silver Creek Lane NW, Bremerton, Washington 98311. My date of birth is October 31, 1928.

I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying vs. State of Washington.

My husband of 42 years, Richard A. Lau, died on October 12, 1995. My husband's desire and intent always was to find the means to hasten his own death when his physical condition was no longer bearable. He died after taking a sufficient supply of drugs prescribed by a physician that took a long search and numerous inquiries to locate.

Richard had been battling lung cancer for two years before he died. The cancer had metastasized from his lungs to his thigh bone, hip, arm, neck and head. His body had become a skeleton and his pain and suffering were worse. He decided it was time to fulfill his wish of assistance in dying. I was always aware of this intention and in total agreement and understanding.

Approximately three weeks prior to Richard's death, he was examined by an independent physician, not his treating physician. This physician verified that Richard was mentally competent, not depressed, and fully aware of the consequence of his decisions. The physician determined that Richard's condition was terminal and that he had no more than one to two months to live. He verified that Richard had lost 62 pounds in the last 15 months and had documented metastases.

Richard decided that he wished to die on Thursday, October 12, 1995. A nurse, my adult daughter, and two trained volunteers from Compassion in Dying were present with him. Everyone checked with Richard to see if he had

changed his decision. He was clear and adamant in his determination to proceed.

Richard was helped with personal care matters, smoked a cigarette and visited with those present. He then personally took the medications. He was very relaxed and at peace and thankfully welcomed his liberation. He always worried so much about finding this assistance and it was a blessing when we did. We did not believe in prolonging suffering needlessly.

At the end, his death at home was very calm and peaceful. I supported him all the way.

I believe all terminal and suffering persons should be able to legally seek supervised and regulated assistance in dying, if that is their wish. Prolonging suffering needlessly is inhumane.

I hereby declare under penalty of perjury under the laws of the State of Washington and of the United States that the above statement is true and correct.

Dated: November 13, 1996

Place of execution: Bremerton, Washington.

/s/
Roberta Lau

PERSONAL DECLARATION OF PATSY McLAUGHLIN McGEORGE

My name is Patsy M. McGeorge (a.k.a. Patsy A. McLaughlin, Ph.D.). My address is 1760 Parson Creek Road, Sedro Woolley, WA 98284-9620. My date of birth is May 27, 1932.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My husband of twenty-five years, Emanuel J. ("Mac") McGeorge, had terminal cancer involving the spine, lungs and lymphatic system. But terminal cancer is cited only as "other significant condition" to his cause of death on the death certificate. The certificate reads: "Death due to or as a consequence of: Massive trauma to head -- self-inflected (sic) gun shot wound-shotgun."

Mac was diagnosed with cancer in November of 1994. Because he was 72 years of age, he rejected massive chemotherapy and radiation and asked just for drugs to ease his then acute pain. For a man who rarely took even aspirin, the nausea, dizziness, and other side effects of simply increasingly higher levels of pain medication served to reaffirm for him the soundness of his decision.

During late spring of 1995, he broached the subject of suicide. It was not the first time suicide had been mentioned, but this time he was quite serious. He told me of his great concern for becoming incapacitated, or so ill that he would either be hospitalized or would not, for some other reason, be able to govern his own destiny. He was relieved to have my assurance that he would never be hospitalized against his wishes, and that I would respect and support any decision he made about ending his own life. Mac also brought up the possibility of assisted suicide with his doctor, but while his doctor was understanding, he was not supportive.

By October, Mac had already surpassed his predicted nine-month life expectancy, but the cancer was taking its toll. He had gone from a man of 190 pounds of muscle, exceptional strength, and superior stamina to a "145 pound weakling." What stamina remained came from sheer will power and intestinal fortitude, yet he managed to put his shop in order, teach me his special techniques in the darkroom and continue his daily routines. By January of 1996, he was able to eat very little; his weight loss was becoming extreme. The principal spinal tumor had grown so large that he referred to his appearance as that of the "Hunchback of Notre Dame." He could only sleep on his side, and despite 800 mg. of morphine a day and Roxicet every two hours, his pain was so extreme that sleep came only in short intervals. He could lie down for only an hour or two at a time. He struggled through January, but by the first of February, he couldn't take much more. We were referred to Hospice, an outstanding group that does a great deal to ease the pain and suffering of the terminally ill, but regrettably cannot assist in ending that suffering. With a subcutaneous pump to assure a continuous morphine flow and additional medication, Hospice nurses were able to provide Mac his first full night's sleep in months. But Mac did not want to be a drugged vegetable. Following an almost 24 hour drugged stupor, he decided that was not the answer.

On the morning of February 9, 1996, he had made up his mind. He said he felt as if he had just been through Ray Milan's "Lost Weekend," and told me that with such a high level of pain medication he would soon be a vegetable, unable to think, do for himself, or control his own destiny -- an intolerable situation. After a brief and very personal conversation, he gave me the note he had carried for months, attesting to the fact that his decision was his own; kissed me goodbye; went into the front yard; put a shotgun in his mouth and pulled the trigger. Since a peaceful death was not available, this was his way to insure death with the dignity he valued so highly. Two months ago I was emotionally wrenched by finding a portion of his upper dental plate 50 feet from the site of his death -- a testament to the violent alternative he was forced to choose.

Mac was not depressed -- the overwhelming pain or alternative of a drug stupor were simply unacceptable to him. Mac honestly believed he, with my support, had the right and the responsibility to control his own destiny.

To say that I miss him would be the understatement of the century. But I esteem his courage, his conviction, and his integrity. I am thankful that he loved me enough to share his most personal emotions. I wish I could have been with him at the end, but he said no, "it will be messy."

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above mentioned is true and correct.

Signed: /s/

Dated: September 27, 1996

Place of execution: Sedro Woolley, WA

PERSONAL DECLARATION OF
LEANNE GALLISON

My name is Leanne Gallison. My address is 7538 - 14th Ave. N.E., Seattle, Washington 98115. My date of birth is February 2, 1952.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My mother, B.J. Olsen, was diagnosed with cancer in August, 1993 at the age of 69. She was given six months to two years to live. In September she started chemotherapy which helped a little. Later, additional chemotherapy didn't help. Sharp pains developed in her chest and her spine. Shortness of breath increased. Chemotherapy made her horribly ill, nauseated around the clock. The doctor ordered radiation therapy to ease the pain. At this time, she began to have seizures. Tumors were discovered in her brain. Radiation was added to treat her brain but this resulted in my mother becoming completely flattened with no stamina, no energy. The doctor predicted that within a month or so, she would begin to feel better, she would regain her strength, and perhaps she and her family could go on a vacation. She never got better. She couldn't even get out of the house.

My mother had been a single woman for 30 years. She was left fatherless when she was 2 and abandoned by her husband when her children were still in school. She built her own successful business, traveled in Africa and the Middle East, and put us all through graduate school. She even volunteered many hours each week at a clinic for disabled children. She was petite, beautiful, and determined. She was not about to give up control over her destiny.

As the pain and sleeplessness increased, and in her housebound state, she began to think about how she could end her life with grace and dignity. The last thing she wanted was to be completely dependent on her family. She asked her doctor for

some barbiturates to "help her sleep." When he realized why she wanted them, he flatly refused. She was terribly discouraged. She had to change doctors to seek help. On her bad days she would ask me, "How am I going to get out of here?" And, "I want to go, and I want to go NOW!" She weighed about 60 pounds. One evening, with her children by her side, she consumed some antinausea medication in mashed fruit, and later swallowed all of the morphine she had left. She fell peacefully asleep. She stopped breathing in two hours.

My mother's terminal illness was awful for me because I was very close to her. I had nightmares for weeks prior to her death. She was desperate, and in spite of my being a nurse, I felt helpless. I just don't see how an assisted suicide is dangerous if it is regulated. It is like a Living Will; I just don't see anything wrong in it.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Date: July 29, 1994
Place of execution: Seattle, Washington
Signature: /s/
Leanne Gallison

PERSONAL DECLARATION OF KAY BECK

My name is Kay Beck. My address is 5024 Nicklas Place N.E., Seattle, Wa. 98105. My date of birth is Jan. 18, 1936.

I prepared this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

On Nov. 11, 1991, I helped my husband, Jack, end his life. In the terminal stages of esophogical cancer, he faced paralysis within days. Paralysis for Jack was a fate worse than death. Always an extremely active, rational, self reliant, responsible person, he fought for his life as long as he could. When it became apparent the end was near our plan was that he would end his life with sleeping pills, as difficult and isolating as that proved to be. On the 10th of November he wrote his suicide note and we prepared the drugs. Jack died the next morning of a drug overdose in the room he loved with me but not our children by his side.

The effect of the law against assisted suicide is to create a conspiracy of silence around the terminally ill at their time of ultimate loss and greatest need. It causes isolation, anguish, desperate acts, and prolonged suffering. I do not wish to go to jail but who is to speak for those who have died alone or those who fear prosecution if I do not.

To classify me as a criminal because I refused to leave my husband's side at his time of greatest loss I find unconscionable. The law against assisted suicide is a travesty, a violation of my rights as an adult. The judicial system must find this law unconstitutional or be prepared to put people like me in jail.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 2, 1994
Place of execution: Seattle, Washington
/s/

PERSONAL DECLARATION OF
ELVIN O. SINNARD

My name is Elvin O. Sinnard. My address is 23 Beckett, Lake Oswego, Oregon 97035. My date of birth is May 30, 1917.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

Sara and I were married for 49 years. She suffered from a very painful heart condition the last eleven years of her life. Two open heart surgeries, several trips across the United States to specialty clinics, and very competent care from her cardiologist failed to relieve the debilitating pain. Finally life became unbearable. She could not even talk to me, her children, or her friends for five minutes without triggering the terrible pain. She wanted to die but we did not know how to do it. We could not ask her doctors since one practiced in a Catholic hospital and the other had a national reputation that would have been destroyed had he broken the law to help her.

She feared over-the counter pills, hearing of all the cases where the person woke up a vegetable. Carbon monoxide was out since she wanted the dignity of dying in her own bed, surrounded by the things she loved. We finally learned of the plastic bag method. On the day of her decision, I was with her up to the point of placing the bag over her head and she said, "Elvin, you must now go to the office because you cannot be implicated in this."

She had to die alone. I was denied my right to be with her when she died. This is not right.

I was taken to the police headquarters and interrogated for two hours attempting to establish a direct action on my part to the suicide. The detectives were polite and seemed sympathetic but they said, "Even though we might agree with your action, we would have to recommend indictment if we could establish a direct action on your part to the suicide. It's the law."

And, this is not right. My act was a loving act, not a criminal act.

A person has the right to control the conditions of their death as much as they have the right to control the conditions of their living.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 2, 1994

Place of execution: Portland, Oregon 97035

/s/
Elvin O. Sinnard

PERSONAL DECLARATION OF PATTY ROSEN

My name is Patty Rosen. My address is 60734 Bristol Way, Bend, OR 97702.

I prepare this Declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

For as long as I can remember I have believed that any person suffering from a terminal or debilitating illness has the right to end their life when they choose. My religious and moral beliefs have never interfered with my ability to listen and empathize as patients have pleaded their case to die. I have even made pacts with friends who feel as I do, agreeing that if the need should ever arise, we will help each other die. I have also talked with my four children about the right to choose, encouraging them to think about it, discuss it, and come to their own conclusions. Then, in one short year the subject of assisting the death of a terminally ill person was no longer clinical and abstract. The person dying was my 25 year old daughter and she asked me to help her die, and I did. I didn't have to assist Jody's death. Jody was still capable of giving herself a fatal dose of medication. But Jody didn't want to die alone. She wanted me there with her, to comfort her, and to make sure she died.

Bone cancer. Invasive bone cancer. Literally, from her head to her toes she was filled with bone cancer. The failure to do follow-up on an obvious, thyroid goiter, first diagnosed when she was 18, had led her, over a five year span, to death's door. Jody was devastated. Angry that she was dying, and furious that it could have been prevented, she asked me to keep her at home and care for her. She was also afraid that if hospitalized she would lose her autonomy. She had been trained as a nurse's aid and had witnessed, first hand, how the rights of patients were violated and didn't want that to happen to her. I was greatly relieved she trusted me so completely because I was frantic to take her in my arms and somehow "make it better." But that never happened. Bedridden, Jody was trapped in a body that barely worked. She slept, medicated, 23 out of 24 hours. Even then her face reflected the

pain she was constantly enduring. She was also losing her sight, tolerated painful procedures for total bowel obstruction, and shuddered with pain if anyone so much as touched her skin because of the tumors that were barely under the surface. And, her bones. Bones that were slowly "burning" ("it feels like hot molten lava inside of me") away with cancer. Daily she let me feel her despair. Daily, her eyes dulled by medication, the question would come: "Mom, how long can you watch me suffer?" "Mom, please help me."

What could I say? Was I going to tell her she would get better? That this was temporary? What reason could I give her not to die when she was already dying? She was dying, she knew it, and she was ready to die now. Rational, calm, ready. However, it was illegal for me to assist and she knew it. "I should be able to talk with my doctor and plan this, not ask my Mom" "Mom, what if you go to prison?" "What will happen to you?" Worry made her small face with the sunken eyes of the near death take on an incredibly distressed look. Wasn't it enough that she was dying without having to worry about me? In my most convincing style I reassured her. Her trust and faith in me were humbling and I was determined not to let her continue to suffer because of what might happen to me. I found the idea absurd.

Finally, four months after her request, choking on my tears, I said, "Jody, I'm ready." A look of relief came over her face. She was, in fact, almost giddy with relief. Quietly, softly she said, "Oh Mom, thank you. This is one of the happiest days for me. I don't have to wake up in this body again." Those words, to this day, make me sob with my own pain of loss. I miss her so much.

And then it was time. Jody calmly swallowed everything I could give her, took a few sips of water, kissed me, "See you later Mom," closed her eyes and went to sleep. I went into a pure panic. What if I failed? What if she regained consciousness? She would be even worse off. But more than that, I would have failed her. I began giving her all the I.V. medications I could pump into her stilled body. I moaned, sobbed, prayed, and kept pushing the drugs. I was as desperate as I have ever been. My mind started playing tricks on me. Looking at her I would suddenly think I had

made a mistake, that she was not terminally ill, but was getting better. I fought the impulse to reach for her, to shake her awake, or to pick up the phone and call for help. I forced myself to stay in the naked reality of the situation, to look at my daughter's withered frame, her cadaver-like skull, and to continue my vigil.

Ten hours after we had started the process came the silence. She had finally stopped breathing. The year and a half of pain, suffering, rage, and hopelessness had ended. I climbed into her bed, gathered her still body into my arms, finally able to hold her without hurting her. Stroking her hair, rocking her gently, I surrender to my grief. A brave and wise young woman, Jody Lynn Grape, age 26, died October 30th, 1986, at 1:30 p.m.

I have never felt guilt or remorse for assisting Jody's passing. It was the ultimate act of love a mother could do for her suffering, dying, child. I am grateful that she trusted me enough to ask, made me feel her anguish, and included me in her dying. Her request was a rational request. She made her decision independently, following her heart and spiritual belief.

The day following Jody's death I rushed to the therapist office seeking any wisdom and comfort she could offer. "Patty, I have Jody's permission to tell you what she said at our last meeting and I want to share it with you now." Leaning forward, taking my hand, she told me Jody's last request: "please don't let anything happen to my Mom."

I hereby declare under penalty of perjury under the laws of the State of Oregon and the United States that the above statement is true and correct.

Dated: November 2, 1996
Place of execution: Bend, Oregon

/s/
Patty Rosen

PERSONAL DECLARATION OF
JEFF (JOSEPH) HALSEY

My name is Jeff Halsey. My address is 1000 - 8th Avenue, #A 806, Seattle, Washington 98104. My date of birth is April 5, 1958.

I prepared this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My partner Danial Danzer's biggest fear was that of losing his mind. He wanted to die before he lost his mind.

Danial had reached the final stages of AIDS. He sought help with his problems from the medical community but didn't receive any. So when he felt his mind was leaving him, he opted for a unique solution to his problem, that being withholding his insulin and letting himself die of insulin shock. It was a very long five days of convulsions, dementia, violent outbreaks, and a total loss of self-dignity.

I feel that had there been a way for him to end his life peacefully, that he would have opted to do so. Danial was lucky in that he had a way to deliver himself--by withholding his insulin. Most people are not that lucky. Most people must suffer even more than Danial suffered.

I couldn't wait for him to die so that he would quit suffering and I would quit suffering. I feel that Danial and I were both robbed of important, quality time by his slow and painful death. He might have been spared some of his greatest pain and retained his dignity if he and his physician had received help from a compassionate code of laws.

He was only 34 years old when he died on June 10, 1994.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 1, 1994

Place of execution: Seattle, Washington

/s/
Jeff Halsey

PERSONAL DECLARATION OF TANIA BLOOM

My name is Tania Bloom. My address is 3110 C Portage Bay Place E., Seattle, Washington 98102. My date of birth is September 28, 1936.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

In 1989, my father was dying of lung cancer and was in excruciating pain. His doctor would not provide pain medication other than Tylenol saying that to do so "would not be medically advisable." Father remained at home and in spite of being hooked up to oxygen, he struggled to breathe. We had access to morphine and hinted to hm that we could get it for him if he wanted it. However, he refused because he knew it was illegal to assist in a suicide.

When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12-gauge shotgun. He was 84.

My youngest daughter did not have the benefit of having her own father during her growing up years so my father became her surrogate father. They became extremely close. The loss of her grandfather was devastating for her. The nature of Dad's suicide added to this tragedy. This was a brutal and awful experience for my children and for me. I felt a great deal of loss, anger, and remorse about a system that would not allow my father to die gracefully and with dignity.

My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.

Physician assisted suicide should be a rational choice and a reassurance for people. Physician assisted suicide can have safeguards and planning so that it wouldn't be an impulsive,

irrational act and one of unnecessary violence such as that of my Dad's.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 28, 1994

Place of execution: Seattle, Washington

/s/
Tania L. Bloom

PERSONAL DECLARATION OF GAIL BERENY

My name is Gail Bereny. My address is 2360 - 43rd Ave. E., #307, Seattle, Washington 98112. My date of birth is _____.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

Several years ago, my 80 year old father was diagnosed as having terminal abdominal cancer. He went to his doctor with two requests, (1) not to prolong things, and, (2) to keep him as pain free as possible. His doctor agreed. However when time came, the doctor did neither. And so my father, to whom dignity was very important, lay dying, diapered, moaning in pain, begging to die. I called the doctor's office, crying, begging him to relieve Dad's pain. He refused, saying morphine could kill him.

My father's brother, my uncle, has a weak heart. He was so distraught that we were frightened for him. Dad's friends did what they could to give him their that love and support. His best friend, a retired cardiologist, was dismayed and angered at the physician's lack of help and compassion. Dad would have been spared at least a week or two, the worst part of his illness.

I felt very guilty then, and feel guilty now, about Dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness. He had been a very good father.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 28, 1994
Place of execution: Seattle, Washington

/s/
Gail Bereny

PERSONAL DECLARATION OF
DOROTHY B. HOOGSTRAAT

My name is Dorothy E. Hoogstraat. My address is Beaverton Oregon. My date of birth is February 9, 1921.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My husband, Emerson E. Hoogstraat, a retired Professor of Finance, from Portland State University, died on March 25, 1995 of prostate cancer that had spread to the bones. He had been diagnosed in March of 1993 as having prostate cancer. We obtained a second opinion and he decided to have surgical removal. The physician did not complete the surgery as the cancer had spread to the lymph nodes. He then had forty radiation therapy treatments and after a few months of relatively pain free existence he again began having problems. In late 1993 he had edema in the right leg from hip to foot, caused by tumors pressing on the blood vessels in the groin and at the suggestion of his urologist had an orchiectomy, which we hoped would relieve the swelling in his leg and slow the spreading of the cancer. He was relatively comfortable until June of 1994 when a series of new problems developed. Following further diagnostic procedures it was ascertained that the cancer had spread to his ribs, spine and right femur. He was in considerable pain when walking, sitting or lying in bed. He had been given medication for the pain prior to this time but it now became a necessity if he was to have any measure of relief. His ribs gradually broke, and as he said to me many times, he could feel the broken edges of the bones rub together as he would sit or attempt to arise from the bed. He was in unbearable pain. He was an extremely intelligent, courageous and dignified man and he did not wish to suffer unbearable pain when there was no hope of recovery from this condition. He would very much like to have gone to sleep in his own bed and not had to suffer further. He felt that it was his right to say when he had suffered enough. He "lived" at least two months after he would have preferred not to. The physicians and Hospice people were constantly changing medications and attempting to make him as

comfortable as possible - which in his condition was an impossibility. It was a twenty-four hour a day caregiving situation and he still suffered unbearably. He remained at home until his death.

He had been very active in promoting Measure 16 - we both had - and he was sad that he was unable to receive help when he so desperately wished and needed it!

We had been married for forty-seven years and shared a lifetime together, and truly, watching him suffer and being unable to do anything for him that would relieve his pain, was for me devastating.

I do not believe it is suicide when a person is terminally-ill and there is no relief for the pain and suffering. Quality of life is very important.

I do not believe that God intended for people to suffer in this manner. We are more compassionate with our pets than we are with our dearly loved family members.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above are true and accurate.

Dated: October 30, 1996
Place of execution: Beaverton, Oregon 97005

/s/
Dorothy B. Hoogstraat

PERSONAL DECLARATION OF GÖSTA PEARSON

My name is Gösta Pearson. My address is 7432 Latona Avenue NE, Seattle, Washington 98115. My date of birth is June 29, 1925.

I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

In 1991, I was with my very good friend, Hugo Vila, when he died. Hugo moved to the United States from Cuba and became an American citizen. He had no family members in the United States and I became a surrogate father to him.

I spent the last few weeks of Hugo's life with him, as he slowly but steadily was dying from AIDS. Hugo remained living in his apartment and I spent several hours each day helping take care of him. At the end, he could not walk and could only use one of his arms. I think he had suffered a stroke which paralyzed one side of his body. He had a catheter attached to him and he was unable to control his bowel movements. Hugo was very upset about messing himself in bed, since he had always been a meticulous person. I had to pick Hugo up, put him in a wheelchair, take him to the bathroom and lift him up and put him in the bathtub, in order to clean him. Hugo had lost a lot of weight and was virtually skin and bones the last few weeks of his life. Hugo needed help in eating and in doing virtually everything in order to continue living.

Hugo told me that he was very concerned about his loss of dignity and ability to care for himself. He was mentally alert and not depressed during this period. Medication controlled his pain, but the loss of dignity was horrible to him. He told me that he had had a full life and he wanted to end his life with dignity, realizing that things were only going to get worse as his AIDS progressed.

On June 20, 1991, Hugo told me that he had decided to take his own life with some pills he had stockpiled. He told me I did not have to stay with him, but I wanted to be by his side. He

prepared two glasses of medication and told me he was going to drink one glass and then follow with the other. He then drank all of one of the glasses. He then told me that "that didn't taste very good--will you get me a spoon of pudding from the kitchen". I did and he said "that's better." Then he reached for the second glass and passed out before taking the second glass of medication.

Hugo was in a coma for the next several days. I immediately called his physician, who came and examined him. Hugo remained in his home, receiving no food or hydration. Medical personnel told me that Hugo could hear us, even though he was not responding to us.

This was the worst seven days of my life. It was miserable for me, for Hugo, and for others to see his desired death stretched out for so long. I slept in his apartment during that week in order to be close to him.

If Hugo had been able to have a physician assist him in his dying, he could have died when and how he wanted, with dignity and without further complications and problems.

A program should be able to be developed so that people don't make the same bungling mistakes Hugo did. It is important for people in Hugo's situation to have the freedom of choice to end their life, without fear and without complications which make their dying process a nightmare.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above mentioned is true and correct.

Signed: /s/

Dated: November 21, 1996

Place of execution: Seattle, Washington

DECLARATION OF KEITH WILLIAM GREEN

1. My name is Keith William Green and I live in Los Angeles, California.

2. I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying vs. State of Washington.

3. I was arrested on December 4, 1995 in West Los Angeles after my lover of eight years committed suicide. Within hours of the arrest, I was charged with murder under California Penal Code section 187 and felony assisted suicide under California Penal Code section 401. I was a defendant in the matter entitled People v. Keith William Green, Los Angeles Municipal Court, West Los Angeles District, Case Number SA023990.

4. In 1991, my lover tested positive for the human immunodeficiency virus ("HIV") and was diagnosed with full blown AIDS in early 1994. He was in the advanced final stages of the disease at the time of his demise. With his immune system entirely compromised he suffered from a panoply of debilitating diseases which were incurable. During that time, I was his primary caregiver, constant companion and, more often than not, his sole source of emotional support.

5. Throughout the last year of his life, he suffered from a variety of ailments including Cytomegalovirus ("CMV") retinitis, an especially frightening condition in which the virus attacks the optic nerve. It had rendered him virtually blind in one eye and was threatening to cause total blindness in both. He suffered from bacterial infections that caused chronic night sweats, fever, chills, malaise, nausea, diarrhea and pain. He had been treated for CMV Colitis by daily intravenous infusions of Foseavir, and suffered from neuropathy, the primary symptom of which is pain throughout the extremities. He could not drive, he could not work, he could not live without pain and anxiety, and he had lost control of most bodily functions.

6. Having witnessed the deaths of many of our friends from AIDS, he was aware of his fate. He unsuccessfully attempted suicide in July 1995 by the ingestion of drugs that he had quietly stockpiled. After several hours of distress and seizure it became apparent that his attempt was flawed so I called 911. Because of his attempt at suicide, he was confined by restraints to a bed at the UCLA Medical Center. It was a horrible experience for the both of us. In the end, the failed attempt only served to increase his sense of helplessness, humiliation and resolve to die on his own terms.

7. He left numerous notarized suicide notes indicating that it was his desire to end his life, that he had made the decision on his own, that the reason was the lack of quality in his life, and he even promised to sue anyone who attempted to revive him.

8. In late November, 1995, he was hospitalized again, with his doctors encouraging surgery on the one eye from which he still had some sight. Fearful that the surgery would render him totally blind, he refused the procedure and left the hospital against medical advice on or about December 1, 1995.

9. On Monday, December 4, 1995, he told me that this would be our last morning together. He went into the bathroom where he remained for a considerable period of time. I learned afterwards that he had been taking a large and lethal quantity of chlorohydrate and seconal. Because his prior attempt at suicide by pills had failed, he had planned to use carbon monoxide as a back up.

10. After a tearful goodbye, he went to the garage where he had set up his car in a manner as to facilitate the ingestion of carbon monoxide. Once seated in the driver's side of his car, he then told me that it was time for me to leave.

11. I left our home and began to drive aimlessly, but was haunted by something he had asked me to promise again and again during our last year together. He had repeatedly asked me to promise him that I would not leave him as his condition worsened. I, in turn, made a commitment that I would indeed never leave him. Unable to silence the memories of these words, I returned to our

home within five to ten minutes of leaving. I went to the garage which was then filled with smoke and stayed with him in the car.

12. Given the circumstances, his decision to commit suicide could hardly be described as anything but a rational choice. Indeed, it was his fundamental natural right. In the same way, it was my right to be by his side, not only to honor the promise made, but also to honor our love and admiration for each other.

13. After having been prosecuted for a felony for six months, the charges were finally dismissed on June 4, 1996. Though released on my own recognizance within a few days of having been arrested, the terms and conditions of my release precluded me from being at his funeral in his home town in Texas as I was not allowed to leave California.

14. I am the one person who stayed by him while everyone else abandoned him as his condition worsened. I am the one person whose love was sufficient to withstand the horrible strain caused by his progressive illness. Despite all that, I am also the one person who was charged with a felony and faced a prison term of up to three years. In the end, the charges that were filed against me were the last thing that he would have ever wanted to happen.

I hereby declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 28th day of November, 1996, at West Hollywood, California.

/s/
KEITH WILLIAM GREEN

DECLARATION OF WILLIAM F. MEYER III

My name is William F. Meyer III. My address is 2 Teragram Place, Westport, Connecticut 06880. My date of birth is April 27, 1929.

I prepare this Declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

In 1991, my father, William F. Meyer Jr., who was 88 years old and had experienced five cancer operations, was in rapidly failing health. The cancer that had begun in his colon had spread to his lungs. He was losing weight and was being eaten away. His doctor said he had only a few months to live.

My father approached me with the idea of taking his life, a suggestion that I immediately rejected since he was my best friend and advisor. For the next several weeks during weekly visits and telephone conversations, I tried to change his mind. After discussing my father's decision with several close friends, plus my minister, who is my spiritual leader (and who talked to my father), I reluctantly agreed to my father's wish. He took many of his close friends, plus selected relatives, into his confidence concerning his intention, and he even prepared a letter which I was to mail to 80 friends and relatives after he had taken his life. The letter said "I happily decided that it was more kind and thoughtful of me to terminate my life before I reached a decadent condition of helplessness."

After my father and I met with my father's doctor of 25 years, my father decided he would use the procedure featured in the book Final Exit, taking 12 sleeping pills and placing a plastic bag over his head.

My father's first attempt at this action failed when his reflex action, which comes from the feeling of suffocating, caused him to pull off the plastic bag. When I returned to my father's home the next morning, he was awake and distressed that he was still alive.

My father consulted with his doctor and was advised that I could hold my father's hands so the reflex action would not remove the plastic bag. My father and I followed this procedure and he was able to end his life.

Since one of my father's last requests was that I tell his story, I joined the Hemlock Society and became a vocal spokesman for death with dignity. In the summer of 1994, I was interviewed for a story by Connecticut Magazine. After the story, I was arrested and charged by the police with second degree manslaughter. If convicted, I faced ten years in prison.

At a hearing in December, 1994, before a Superior Court judge in Hartford, Connecticut, two ministers and several friends spoke on my behalf. Numerous people, including eleven ministers and eighteen doctors, wrote to the judge to support me. Even though the District Attorney pleaded that my case go to trial, the judge stated that although I had broken the law, I was following my father's wishes, and the judge considered me an outstanding citizen. I was given two years "accelerated rehabilitation" (after two years, all charges are dropped, with no record).

I was and am still amazed at how many people relate stories of prolonged, painful suffering of relatives or friends. They called my story an act of courage and common sense. There is a legion of people who live with a "secret agony" over watching a loved one waste away.

From a religious standpoint my act of love for my father is consistent with my church's beliefs. As a most loyal and active member of the United Church of Christ, I concur with our statement, "We affirm individual freedom and responsibility to make choices in these matters."

I hereby declare under penalty of perjury of the laws of the State of Connecticut and the United States that the above statement is true and correct. Executed at Westport, Connecticut, on _ December 2, 1996 .

/s/
William F. Meyer III

PERSONAL DECLARATION OF STEVE KNIPP

My name is Steve Knipp. My address is 150 Melrose Ave. E., #102, Seattle, Washington 98102. My date of birth is May 28, 1962.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My partner, Tom Andolina, was diagnosed with AIDS in February, 1990. His condition worsened to the point that he was homebound and in a great deal of pain. Pain medications were not working. Doctors would not prescribe medications to help him end his life so he was forced to stockpile medications until he had enough. He died on December 1, 1991, alone, because of fear of anyone stopping him if they were present.

We had planned on the time and the day. He was so wrapped up for so many weeks planning his exit that he was unable to enjoy what life he had left. He was very frustrated at how to commit suicide; he didn't know how. There was no way that we could find out how much medication he would need. We both struggled with it for months. He didn't want to do anything violent or painful. We didn't want him to commit suicide, but he was in too much pain and had become housebound. The quality of his life was severely diminished. He also had a fear that if he failed in his attempt, he would be resuscitated.

Because he was afraid of my reaction, he decided to do it alone. It was a terrible shock to wake up one morning and find him dead in the livingroom. He had been dead for eight hours. I was obviously devastated. We had been partners for ten years. Our friends were very upset that they couldn't be with him to say goodbye.

It was a very lonely death. That's the one thing I will never get over. My mother came from out-of-state to be with me for a

period of time as she was concerned for my emotional health. I was in therapy for six months.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 31, 1994

Place of execution: Seattle, Washington

/s/
Steve Knipp

PERSONAL DECLARATION OF JINNY TESIK

My name is Jinny Tesik. My address is 3307 N.E. 125th, Seattle, Washington 98125. My date of birth is April 20, 1942.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

In 1986, I took a leave of absence from my position on a Seattle Hospice Team to help my father care for his terminally ill wife (my stepmother) of 36 years. She died slowly and stoically from lung cancer. We were with her at home when she died. For over two years, Dad watched his handsome wife succumb to the ravages of the disease. He honored the choices she made in her care and treatment even though they wouldn't have been what he would have chosen for himself.

Unable to live alone due to his own battle with emphysema, Dad lived with me for the last two years of his life. He was adamant that he would not let his disease control him the way his wife's lung cancer controlled her. He intended to take his life while he still had his dignity, self-respect, and , above all, was still in control of his life. He made me promise that I would honor his choice. He threatened that if the means for him to take control of his death were not available, he would kill himself with a kitchen knife.

The emphysema progressed. Dad was tethered to 30 feet of oxygen tubing; he seldom left his bedroom. Breathing became more difficult and eating became a problem. His physician was totally opposed to providing the help Dad requested. One morning, he reminded me of my promise to help him. He discussed his plan rationally, non-emotionally. He was ready to die and needed my support. We raided the medicine cabinet and I was sent out to buy some vodka. We spent the day together. Toward evening, he asked me to leave the house and not return until very late. He did not want me to be implicated in any way in his suicide. Saying

goodbye to my dad was one of the saddest times of my life. And I had to go through that long night alone for I, in turn, could not implicate anyone else in the knowledge of my dad's death. He died in 1990 at the age of 76.

My 39 year old husband committed suicide violently ten years ago by shooting himself in the head. That is the kind of suicide that leaves the legacy of guilt, anger, and unanswered questions. That kind of suicide devastates and destroys those left behind.

After 12 years of working in hospice and as a grief counselor, I have heard far too many cases of others like my father who chose to be in control of their deaths. For those who choose their own death in their own time, let it be peaceful, loving and legal, not shattered by violence and shame.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 1, 1994

Place of execution: Seattle, Washington

/s/

Jinny Tesik

(58) (60)

Nos. 96-110 and 95-1858

Supreme Court, U.S.
FILED
DEC 10 1996
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, et al.,

Petitioners,

vs.

HAROLD D. GLUCKSBERG, M.D., et al.,

Respondents.

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, et al.,

Petitioners,

vs.

TIMOTHY E. QUILL, M.D., et al.,

Respondents.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND AND NINTH CIRCUITS

BRIEF OF THE WASHINGTON STATE PSYCHOLOGICAL ASSOCIATION, THE AMERICAN COUNSELING ASSOCIATION, THE ASSOCIATION FOR GAY, LESBIAN AND BISEXUAL ISSUES IN COUNSELING, AND A COALITION OF MENTAL HEALTH PROFESSIONALS AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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December 10, 1996

61 pp

QUESTION PRESENTED

Whether a State may prohibit physicians, completely and under any set of circumstances, from providing mentally competent, terminally ill adults with the means medically necessary to choose the manner and timing of their death.

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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

No. 96-110

STATE OF WASHINGTON, et al., *Petitioners*,

v.

HAROLD GLUCKSBERG, M.D., et al., *Respondents*.

No. 95-1858

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, et al., *Petitioners*,

v.

TIMOTHY E. QUILL, et al., *Respondents*.

ON WRITS OF CERTIORARI TO
THE UNITED STATES COURTS OF APPEALS
FOR THE SECOND AND NINTH CIRCUITS

BRIEF FOR THE WASHINGTON STATE PSYCHOLOGICAL ASSOCIATION, THE AMERICAN COUNSELING ASSOCIATION, THE ASSOCIATION FOR GAY, LESBIAN AND BISEXUAL ISSUES IN COUNSELING AND A COALITION OF MENTAL HEALTH PROFESSIONALS AS AMICI CURIAE SUPPORTING RESPONDENT

INTEREST OF THE AMICI[1]

Any consideration of the question before the Court in this case must involve the related issues of (i) whether a mentally competent adult patient would ever freely choose to hasten death, and (ii) whether it is possible to ascertain that a particular patient is mentally competent, adequately advised, and has freely made such an irrevocable choice. The amici are mental health professionals whose training and experience qualify them to provide the Court with insight on these important questions.[2]

The Washington State Psychological Association ("WSPA") is a non-profit professional association of approximately 900 doctoral level psychologists, and other related mental health practitioners. The WSPA's mission is to support, promote and advance the science and practice of psychology in the public interest. Many WSPA members work in areas directly affected by the issues raised by physician-assisted suicide, and confront the problems faced by terminally ill patients and their families on a regular basis. WSPA members routinely assess the mental capacity of patients, including those who are terminally ill and those contemplating suicide. By reason of the skills, training and experience of its members, WSPA believes it can provide meaningful insight into the mental capacity of terminally ill patients and into the diagnostic and evaluative resources available to verify such capacity. While the existence of a constitutional right to die is a legal question beyond the

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[1] This Brief is being filed with the written consent of all parties in accordance with Sup. Ct. R. 37(2)(a).

[2] Mental health professionals include psychiatrists, psychologists, social workers, professional counselors and marriage and family therapists.

special expertise of WSPA, WSPA hopes to demonstrate that evaluative processes do exist for reliably assessing mental capacity, even for patients who are terminally ill, and even for patients who may contemplate suicide.

The American Counseling Association ("ACA") is the largest non-profit organization of professional counselors in the United States, with approximately fifty-five thousand members. ACA is an educational, scientific, and professional organization whose members are dedicated to the enhancement of human development throughout the life span, and who work to support and enhance the worth, dignity, potential and uniqueness of each individual. Indeed, the ACA's Code of Ethics and Standards of Practice states that "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." Many of ACA's members provide mental health services, including psychotherapy and psychological assessments. Professional counselors serve in private practice, community mental health centers, mental health agencies, schools, universities, hospitals, rehabilitation facilities, business, industry, correctional institutions and religious organizations. ACA's members are trained in the diagnosis, etiology, and treatment of mental and emotional disorders, including depression. Given the counseling profession's largely unique focus on human development, and on individual self-determination and self-actualization, ACA feels it imperative to express its position regarding the ability of terminally ill adults to choose the manner and hasten the timing of their death.

The Association for Gay, Lesbian & Bisexual Issues in Counseling ("AGLBIC") is an association of gay and non-gay professional counselors seeking to promote greater understanding and insight toward counseling gay, lesbian and bisexual clients. AGLBIC offers professional training for all counselors interested in developing clinical skills that will

enable them to be more effective. AGLBIC's interest in these cases stems from its members' experience with gay, lesbian, and bisexual persons with HIV disease.

The Coalition of Mental Health Professionals Supporting Individual Self-Determination in Decisions to Hasten Death is an ad hoc group of academics, private practitioners, administrators and consultants. These individuals have training and experience in the mental health professions which makes it appropriate for them to offer their views on the possibility of free and rational choice in the context relevant to this case. All Coalition members have extensive experience providing psychotherapy, often to persons who are terminally ill, and/or strong records of research and writing on depression, grief, suicide, psychotherapy, personality disorders, and substance abuse. A list of Coalition members is attached to this brief as Appendix A.

SUMMARY OF ARGUMENT

The decisions of the courts of appeals in these cases limit their holdings to a narrow set of circumstances: cases involving mentally competent, terminally ill adults who have made, or wish to have the option to make, the choice to select the manner and hasten the time of an otherwise quickly and inevitably approaching death. Implementation of either decision therefore depends on the ability to assess whether a terminally ill patient is mentally competent, and whether a particular decision to seek assistance in dying is rational and voluntary. These central issues of the competence, rationality, and voluntariness of end-of-life decisions are ones with respect to which many mental health professionals have special training and experience.

Two central values for mental health professionals are the intertwined principles of client autonomy and self-determination. Mental health professionals do not promote

any particular resolution of the terminal-care issues that may arise near the end of a client's life. Rather, in the context of end-of-life decisions, clients are helped by providing them with the means to make informed choices.

In determining legal competence, courts have inevitably relied on the training, experience, and judgment of qualified mental health professionals to assess an individual's capacity to make reasoned decisions. In the context relevant to these cases, there is no dispute that States may appropriately set high standards for making such assessments. Under existing or suggested standards, an evaluator would focus, for example, on a patient's ability to make a coherent assessment of costs and benefits and to draw conclusions that are logically consistent with his or her own values, rather than on the particular outcome of the patient's deliberation. Once appropriate standards have been set, mental health professionals who have the requisite training, experience, and direct contact with an individual patient will be in a position to assess whether the patient has the capacity to make a reasoned end-of-life decision.

There should be no dispute that, before allowing a physician to assist a terminally ill patient to hasten death, a State may also constitutionally require some particularized assessment of the patient's end-of-life decision. Although some have argued that *any* decision to hasten the end of one's life must be either irrational or the product of mental illness, that argument is merely conclusory. Evaluation of particular decisions must instead focus first and primarily on the deliberative process involved, not on the decision ultimately made. Similarly, neither research nor experience supports the assertion that decisions to hasten death are so highly correlated with mental illness as to justify a prophylactic rule banning all physician assistance in dying. Rather, research indicating that terminal illness, particularly

if accompanied by intractable pain or other special circumstances, presents a special case for rational suicide is reinforced by studies showing that a significant proportion of mental health professionals believe that hastening death can be a reasonable choice. Under proper circumstances, a choice to control the manner and hasten the time of one's own death is neither inherently irrational nor indicative of mental illness.

Mental health professionals who work with terminally ill patients are as concerned as others that decisions to hasten death not be impulsive or ambivalent, and that they be made free from any coercion or undue influence. Such dangers may largely be avoided through appropriate state regulation, including mandatory waiting periods and the involvement of mental health professionals in evaluation and counseling. With a strong commitment to patient autonomy as a guiding principle, mental health professionals are uniquely suited to serve as counselors and advocates for terminally ill patients in the face of any improper pressure. Moreover, appropriate safeguards may be put in place without denying patients who are in a position to make free, informed, and intelligent end-of-life decisions the opportunity to do so.

Frank discussion of end-of-life issues among terminally ill patients, their treating physicians, and appropriate mental health professionals would necessarily raise the issues of capacity, rationality, and voluntariness discussed in this brief. The process of evaluation and counseling that should accompany any end-of-life decision will often lead patients to choose some option other than assisted suicide — even if the patient actively considers that course as one possibility. The cases before the Court involve what is presently, and is likely to remain, a minority of patients who reach a carefully considered decision to hasten the end of life, even after a thorough exploration of the alternatives. Nonetheless, various

considerations suggest that protection of the public would be enhanced, not diminished, by bringing physician assistance in dying into the open and allowing for comprehensive legal regulation.

ARGUMENT

I. RECOGNITION AND IMPLEMENTATION OF THE CONSTITUTIONAL RIGHT AT ISSUE IN THESE CASES DEPENDS ON THE ABILITY TO ASSESS WHETHER A TERMINALLY ILL PATIENT IS MENTALLY COMPETENT, AND WHETHER SUCH A PATIENT IS ACTING RATIONALLY AND VOLUNTARILY WHEN HE OR SHE SEEKS ASSISTANCE IN CHOOSING THE TIME AND MANNER OF DEATH.

This case presents the narrow but important question whether a State may constitutionally prohibit physicians, under any set of circumstances, from providing mentally competent, terminally ill adults with the means medically necessary to choose the manner and hasten the timing of their death. In the opinion below in No. 96-106, the Ninth Circuit recognized "a constitutionally protected liberty interest in determining the time and manner of one's own death." *Compassion in Dying et al.* v. *State of Washington et al.* 79 F.3d 790, 793 (9th Cir. 1996). The court then held that, in the particular context of a competent, terminally ill patient whose physician is willing to prescribe appropriate medication, that interest outweighs even the State's substantial general interest in preventing suicide. In that context, the court held, "the state has wide power to regulate, but it may not ban" willing physicians from providing medical assistance to a competent patient who chooses to hasten the already fast-approaching end of life.

In No. 95-1858, the Second Circuit reached a similar result through different reasoning. That court first determined that New York law recognizes and respects a terminally ill patient's right to refuse or order the discontinuance of life-sustaining treatment, including artificial nutrition and hydration. *Quill et al.* v. *Vacco et al.* 80 F.3d 716, 727-28 (2d Cir. 1996). The court then concluded that the State treats other competent, terminally ill patients unequally, by prohibiting even a willing physician from prescribing appropriate drugs if and when such a patient wishes to hasten the moment of his or her own impending death. *Id.* at 729. In the limited context of mentally competent, terminally ill patients, the court discerned no rational relationship between that inequality of treatment and any legitimate state interest. *Id.* at 730-31. The court therefore struck down the State's criminal prohibition on assisting suicide, as applied to "prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness." *Id.*

Although the opinions below rest on different legal theories, both are notable for the care they take to limit their holdings to a narrow set of factual circumstances: cases involving mentally competent, terminally ill adults who have made, or wish to have the option to make, the choice to select the manner and hasten the time of a quickly and inevitably approaching death. Whatever the proper legal analysis, both decisions therefore depend on two important factual propositions: that it is generally possible for a competent person to make a reasoned decision to hasten the end of his or her own life, and that it is possible in any given case to assess the decision-making capacity of an individual patient and the soundness of his or her decision-making process.

Moreover, whether the right in question is guaranteed directly by the Constitution, or as a matter of parity with rights already afforded by a State to individuals who wish to terminate life-sustaining care, both decisions seek to protect a sphere of personal autonomy — specifically, an individual's right to choose the time and manner of ending the suffering caused by a terminal illness. That protection is only sensible or desirable, however, if the choice protected is in fact an autonomous decision made by the individual patient. Conversely, the State's interest in regulating, or even prohibiting, end-of-life decisions of this type increases to the extent that there is any uncertainty about whether a particular patient's choice is truly voluntary.

These central issues concerning the competence, rationality, and voluntariness of end-of-life decisions are ones with respect to which many mental health professionals have special training and experience. Moreover, the mental health professions have long grappled with the ethical issues that arise in this context. The amici offer the following observations to the Court in the hope that they will be helpful in informing the Court's decision on the important question presented by these cases.

II. MENTAL HEALTH PROFESSIONALS ARE GUIDED IN THEIR APPROACH TO END-OF-LIFE ISSUES BY ETHICAL PRINCIPLES THAT INCLUDE PATIENT AUTONOMY AND SELF-DETERMINATION, BALANCED BY LEGAL NORMS AND CONCERN FOR PUBLIC WELFARE.

The analysis provided in this brief is grounded in underlying ethical principles that guide the work of mental health professionals. Mental health professionals accord appropriate respect to individuals' fundamental interests in

privacy, self-determination, and autonomy, while remaining mindful that those interests may conflict with legal and other obligations. When conflicts occur, professionals attempt to resolve them and to perform their roles in a responsible fashion that avoids or minimizes harm. They are aware of their professional and scientific responsibilities to the communities and society in which they work and live. Professionals apply and make public their knowledge of mental health in order to contribute to human welfare. They work to identify and mitigate the causes of human suffering.

Two central values for mental health professionals are the intertwined principles of client autonomy and self-determination. In the context of end-of-life decisions, clients are helped by providing the means for them to make informed choices. Mental health professionals do not promote any particular resolution of the terminal-care or other issues that may arise near the end of a patient's life. Rather, mental health workers who have appropriate training and immediate involvement with those suffering from terminal illnesses can help patients to explore, ameliorate, cope with, or solve problems that interfere with the patient's own control over his or her life and death.

Professionals can, for example, help patients to address issues such as pain, depression, dignity, tranquility, financial concerns, and the effectiveness or futility of available medical treatments. In addition, they can assist the patient to communicate with other health care providers, family members, social service providers, or others concerning the patient's needs, concerns and preferences, to help ensure that the patient receives necessary support and that the treatment provided comports with the patient's wishes. Finally, professionals can promote and monitor appropriate involvement by significant others in a patient's end-of-life decisions, and they can counsel both patients and survivors

in the inevitable process of grieving. *See generally, e.g.*, National Association of Social Workers, *Client Self-Determination in End-of-Life Decisions, in* Social Work Speaks: NASW Policy Statements 60 (3d ed. 1994) "NASW *Statement*", (reprinted as Appendix B hereto). In all these roles, mental health professionals seek to advance the ideals of client autonomy and self-determination, subject to the requirements of the law and concern for the general public welfare.

III. IT IS POSSIBLE TO ASSESS WHETHER OR NOT A TERMINALLY ILL PATIENT WHO HAS REQUESTED ASSISTANCE IN HASTENING DEATH IS MENTALLY COMPETENT AND HAS MADE A REASONED, INFORMED, AND VOLUNTARY DECISION TO SEEK SUCH ASSISTANCE.

A. Assessing Capacity to Make Reasoned Decisions

Both decisions below begin with the assumption that a terminally ill patient who seeks assistance in choosing the means and time of his or her own death must be "mentally competent" to make that final decision. Similar situations involving the assessment of mental competence or capacity arise in a variety of legal contexts, from competence to stand trial to competence to make a valid will. *See, e.g., Cooper* v. *Oklahoma*, 116 S. Ct. 1373 (1996) (competence to stand trial); *Addington* v. *Texas*, 441 U.S. 418 (1979) (involuntary civil commitment); Cal. Prob. Code § 812 (West Supp. 1996) (specifying criteria to be used in determining legal incapacity to perform various acts, including "to contract, to make a conveyance, to marry, to make medical decisions, to vote, or to execute wills or trusts."). Competence is a legal

question, which, when disputed, must ultimately be resolved by the courts. In deciding such issues, however, courts have inevitably relied on the training, experience, and expert judgment of qualified mental health professionals to assess a given individual's capacity to make reasoned decisions. *See, e.g., Medina* v. *California*, 505 U.S. 437, 450 (1992); *see also id.* at 465 (Blackmun, J., dissenting).

Particular legal standards of competence vary depending on the rights and interests at stake in a given context. *See, e.g., Cooper*, 116 S. Ct. at 1383-1384 (contrasting standards for involuntary commitment and for competence to stand trial). In the context of patients' end-of-life decisions, there is no dispute that the standards for assessing decision-making capacity and legal competence may appropriately be set high. *Cf. Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 282-284 (1990); *Addington*, 441 U.S. at 423 ("The function of a standard of proof . . . is to 'instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.'"). While each State could establish its own standards and procedures for such cases, the mental health literature suggests that an appropriate standard would require that a terminally ill patient be able to:

(a) understand and remember information relevant to an end-of-life decision;

(b) appreciate the consequences of the decision;

(c) indicate a clearly held and consistent underlying set of values that provide some guidance in making the decision; and

(d) communicate the decision and explain the process used for making it.

See J. Werth, *Rational Suicide? Implications for Mental Health Professionals* 94 (1996).[3] A strict standard might also require that

> "once understanding [of the information relevant to an end-of-life decision] has been attained, the patient's rational manipulation of information [must take] place in the context of the patient's appreciation of the nature of his situation."

Appelbaum and Roth, *Competency to Consent to Research*, 39 Archives Gen. Psychiatry 951, 954 (1982).

Under this type of standard, a mental health professional evaluating decision-making capacity would examine a patient's "chain of reasoning," and would seek to determine whether the patient can "indicate the major factors in his decisions and the importance assigned to them." Appelbaum and Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 New Eng. J. Med. 1635, 1636 (1988). The evaluation would focus on the patient's ability to make a coherent assessment of costs and benefits, and to draw conclusions that are logically consistent with his or her own values or other stated premises for the decision, rather than on the outcome of the patient's deliberation. *See also* Annas and Densberger, *Competence to Refuse Medical Treatment:*

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[3] *See also, e.g.*, Drane, *The Many Faces Of Competency*, 15 Hastings Center Report No. 2, 17, 19 (1985); Freedman, *Competence, Marginal and Otherwise; Concepts and Ethics*, 4 Int'l J.L. and Psychiatry 53, 59-60 (1981); Roth et al., *Tests Of Competency To Consent To Treatment*, 134 Am. J. Psychiatry 279, 280-282 (1984); Tepper and Elwork, *Competence To Consent To Treatment As A Pyscholegal Construct*, 8 Law and Human Behavior 205.

Autonomy vs. Paternalism, 15 U. Tol. L. Rev. 561, 568 (1984).[4]

Once an appropriate standard has been set, mental health professionals who have the requisite training, experience, and direct contact with an individual patient will be in a position to assess, in the first instance, whether a patient has the capacity to make a reasoned end-of-life decision.[5] Many

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[4] Compare Cal. Prob. Code § 813 (West Supp. 1996):

> A person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:
>
> (a) Respond knowingly and intelligently to queries about that medical treatment.
>
> (b) Participate in that treatment decision by means of a rational thought process.
>
> (c) Understand all of the following items of minimum basic medical treatment information with respect to that treatment:
>
> (1) The nature and seriousness of the illness, disorder, or defect that the person has.
>
> (2) The nature of the medical treatment that is being recommended by the person's health care providers.
>
> (3) The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.
>
> (4) The nature, risks, and benefits of any reasonable alternatives.

See also Calif. Prob. Code § 1881 (West Supp. 1996) (standards of informed consent for conservatees).

[5] This Court has commented that "the subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations." *Medina*, 505 U.S. at 451, *quoting Addington*, 441 U.S. at 430; *see also Cooper*, 116 S. Ct. at 1382. In this context as in other areas of law (or medicine), however, the impossibility of certainty does not obviate the need to decide. *Id.* at 1382-83. The nature of end-of-life decisions would certainly justify a State in adopting a legal standard

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mental health professionals have extensive experience in making both formal written evaluations and ongoing, informal assessments of decision-making capacity and rationality during the course of psychotherapy, counseling, or psychiatric consultation in medical settings. Indeed, professional evaluation occurs continuously during therapy and within the context of hospital or outpatient consultations. Is the client sensing, perceiving and comprehending information regarding his or her situation accurately? Is the client realistically formulating and utilizing this information? Are the client's perceptions being unduly influenced by mental disorders, prescribed medications, substance abuse, or external social or economic pressures? Overall, is the client fully informed and rational? General criteria exist, and specific criteria may be adopted, for making such evaluations in the case of terminally ill patients who seek physician assistance in controlling the manner and timing of their deaths. *See*, *e.g.*, J. Werth, *supra*, at 94-95. Specification and refinement of those criteria, and their application in particular instances, are well within the competence of the mental health profession.

B. Assessing the Rationality of a Decision

Even if a person generally has the capacity to make reasoned judgments, he or she may make particular choices that are unduly influenced by factors not associated with rational decision-making, such as coercion, inadequate treatment, prescribed medications, drugs, alcohol, or mental disorders. There should be no dispute that, before allowing

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[5](...continued)
under which close cases are resolved in favor of preserving the medical status quo. *See Cruzan*, 497 U.S. at 283. But the inevitability of close cases cannot, by itself, justify imposing a flat prohibition that will apply even in cases where the evidence of mental capacity is clear.

a physician to assist a terminally ill patient in selecting or hastening the moment of death, a State may constitutionally

require not only an assessment of general mental capacity, but some particularized assessment of the patient's end-of-life decision. If allowed to address the issue openly, without fear of legal or ethical repercussions, mental health professionals can provide such assessments. *See*, *e.g.*, Holtby, *Social Work, Suicide, and Self-Deliverance*, 1 National Social Work AIDS Network Readings and Writings No. 3, 30 (1996); Quill et al., *Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380, 1381-82 (1992); J. Werth, *supra*, at 55-80. Moreover, the involvement of mental health professionals and the use of open discussion and evaluation can facilitate the sort of full consideration that leads to an informed and deliberate decision, whatever it may ultimately be.

1. *"Inherent irrationality"*

It may be argued that *any* decision to hasten the end of life must be either irrational or a product of mental illness. *See, e.g.*, Brief for the American Suicide Foundation, Amicus Curiae, Supporting Reversal (Case No. 96-110) 5-11, 13 ("Am. Cur. Br. for the ASF"). That argument, however, assumes its conclusion. For example, one of the guiding principles for mental health professionals is client autonomy — allowing and encouraging clients to take control of their lives and assume responsibility for their decisions. In the argument for the inherent irrationality of suicide, however, a patient who chooses to forgo medical treatment is said to make only "a judgment about how to live before one dies," *id.* at 13, while a patient who desires to exercise essentially the same control over the final portion of his or her life by choosing the time and manner of death is characterized as "afflicted" by a "rigidity" that reflects

"impaired thought processes and irrationality," *id.* at 8. Similarly, the right to forgo treatment is treated as "rooted in our abhorrence of the violence inherent in forcing medical interventions on unwilling, competent adults," but the essentially identical choice to avoid the same "intense burdens, such as pain, bodily invasion, and the emotional suffering that can accompany . . . a course of treatment" by an active hastening of death is dismissed as necessarily a product of "mental impairment." *Id.* at 13-14. Thus, the argument succeeds only because it *defines* a request for active assistance in dying as "irrational."

As with determinations of competency and decision-making capacity, evaluation of a particular end-of-life decision must instead focus first and primarily on the deliberative process involved, not on the decision ultimately made. "If the reasoning process flows logically from its starting premises, though the result might be rejected by most people (*e.g.*, a person refusing potentially life-saving medical treatment), we cannot say that rational manipulation is impaired." P. Appelbaum and T. Gutheil, *Clinical Handbook of Psychiatry and the Law* 223 (1991). A patient who is fully informed, realistic, stable, and not mentally impaired — as determined, for example, by professional observation of the patient's behavior and ability to interact and communicate — may make a knowing and intelligent decision to decline (or accept) treatment, or to request (or decide against) assistance in dying. That is true even if the decision is based in part on "irrational" or super-rational factors, such as religious beliefs or other transcendent moral values.

To be sure, assessing the soundness of a terminally ill patient's decision to hasten death will sometimes present special challenges. In cases of terminal illness, the criteria for measuring the existence of mental disturbance are

particularly likely to be confounded by the effects of the physical disease itself. For similar reasons, it may be difficult to differentiate between normal grief — a reaction to actual or prospective loss — and clinical depression. *See* R. Neils, *Dying Well Network: Death with Dignity FAQs (Frequently Asked Questions)* § 4.18 (a copy of which has been lodged with the Clerk). Indeed, of the nine standard criteria for diagnosing a "major depressive episode," several may be present simply because of physical illness, and six may appear in a terminally ill patient simply because of natural grieving over the functional impairment caused by serious illness and over the impending loss of his or her life.[6]

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[6] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* lists nine criteria for identifying a Major Depressive Episode. A grievously ill person who is not clinically depressed may meet criteria 2, 3, 4, 5, 6, and 9:

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (*e.g.*, feels sad or empty) or observation made by others (*e.g.*, appears tearful);

2) Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day (as indicated by either subjective account or observation made by others);

3) Significant weight loss when not dieting or weight gain (*e.g.*, a change of more than 15% of body weight in a month) or decrease or increase in appetite nearly every day;

4) Insomnia or hypersomnia nearly every day;

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down);

6) Fatigue or loss of energy nearly every day;

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick);

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as

(continued...)

With training and experience, however, a professional can distinguish clinical depression from physical illness or grief, for example on the basis of a patient's feelings of worthlessness or excessive guilt. An individual's sense of self-worth is typically unaffected by physical illness or grief, but significantly impaired in cases of clinical depression. Thus, a depressed patient might inappropriately request suicide precisely because of feelings of worthlessness and guilt. For a terminally ill patient, on the other hand, being able to assert some modicum of control over the course of an inevitable final illness, by choosing at least the time and manner of death, may be a final act of will that reflects — indeed, affirms — self-esteem and individual dignity. The differences between these situations may sometimes be subtle, but they are real, and mental health professionals who work with the terminally ill are qualified to assess them.

An assessment of any particular end-of-life decision should take into account not only the patient's ability to reason coherently, but also the information that the patient has considered in reaching his or her decision. Even if a patient receives fully adequate medical care, his or her physicians may be focused on the details of particular medical problems, rather than on the patient's entire circumstances. The patient will also inevitably be under considerable mental and physical stress. Mental health professionals can provide objective information and counseling about the patient's overall situation, including

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[6](...continued)

observed by others); and/or

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicidal attempt or a specific plan for committing suicide.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 327 (4th ed. 1994).

alternatives of which neither the patient nor his or her attending physicians may be aware. *See* N. Peruzzi et al., *Ethics and Behavior* 8-13 (forthcoming 1997); *NASW Statement*, *supra*, at 60. They may, for example, be able to provide information about alternatives such as hospice programs, independent or assisted living arrangements, and potential sources of financial or other assistance. They can act as liaisons or patient advocates in coordinating comprehensive care. They are also well positioned to assess the patient's overall psychological state, and to recognize signs of misunderstanding, clinical depression, or other factors which suggest that the patient's decision-making ability may be compromised. They can offer the patient a sympathetic sounding-board, identify the factors that appear to be driving an end-of-life decision, and offer either confirmation that the facts are as the patient perceives them to be, or new or different information that may change or help to inform the patient's decision.

2. *Correlation with mental illness*

Even if some decisions to request assistance in dying may be fully informed and intelligently made, it may be argued that a decision to hasten death is so highly correlated with mental illness that the State is justified in enacting a prophylactic rule banning all physician assistance in dying. *Cf.* Black and Winokur, *Suicide and Psychiatric Diagnosis*, *in* Suicide Over The Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal Patients 135, 139 (S. Blumenthal and D. Kupfer eds., 1990) ("few suicides occurred in persons judged not mentally ill, suggesting that the 'rational' suicide is uncommon."). In fact, the correlation between all suicide

and mental illness may be overstated.[7] Even if the

[7] Research indicating that the majority of individuals who commit suicide have one or more mental illnesses may be misleading. Even accepting the data as reported, these studies also show that from 3%-12% of people who have killed themselves had no mental illness. Black and Winokur, *supra*, at 139; Clark and Horton-Deutsch, *Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides, in* Assessment and Prediction of Suicide 144, 148-49, 153-54 (R. Maris et al., eds., 1992). Other researchers report studies in which more than 25% of completed suicides did not have a mental disorder and could be considered rational. See R. Maris, *Pathways to Suicide: A Survey of Self-Destructive Behaviors* (1981); Meerloo, *The Multifarious Motivations for Suicide, in* Suicide and Mass Suicide 18, 25 (J. Meerloo ed. 1962); Patel, *Pathology of Suicide*, 13 Medicine, Science, and the Law 103, 106 (1973). After studying suicide notes, Tuckman, Kleiner, and Lavell stated that they "were impressed with the possibility that in a number of cases the suicide could have resulted from a conscious, 'rational' decision reached by weighing the pros and cons of continuing to live." Tuckman et al., *Emotional Content of Suicide Notes*, 116 Am. J. Psychiatry 59, 62 (1969). *See also* Shneidman et al., *The Suicide Prevention Center, in* The Cry for Help 6, 13 (N. Farberow and E. Shneidman eds., 1961) ("A large minority of suicides, usually older persons in physical pain, are logical and rational and not psychotic.")

Other studies suggest that the data linking suicide and mental illness may be oversimplified. Tanney noted that dramatic differences appeared when studies of the association between mental illness and suicide are broken down into general population surveys and hospital surveys. He reported that, on average, only 38% of completed suicides in the general population had a known history of mental disorder, while, on average, more than 80% of suicides in hospital-based surveys had a psychiatric disorder or history of care. Tanney, *Mental Disorders, Psychiatric Patients, and Suicide, in* Assessment and Prediction of Suicide 277, 283-84 (R. Maris et al. eds., 1992) Similarly, Temoche, Pugh, and MacMahon reported all the highest estimates (47%-94%) of the percentage of suicides who displayed prior evidence of mental illness come from studies done *after* the suicide occurred; in studies dependent

(continued...)

correlation holds for suicides in general, however, the argument for a prophylactic ban is not persuasive in the context of end-of-life decisions by terminally ill patients. In that context, physician-assisted "suicide" is far less akin to what is commonly termed suicide — typically a violent self-destructive act related to feelings of worthlessness — than it is to the thoughtful decision to decline life-sustaining treatment. The latter is a choice that upholds and affirms the dignity of a fully lived life, and one that many States, including New York and Washington, have already recognized as worthy of legal recognition. *See, e.g., Compassion in Dying*, 79 F.3d at 817-20; *Quill*, 80 F.3d at 727-28.

In fact, a number of researchers and clinicians have recognized that terminal illness, particularly if accompanied by intractable pain or other special circumstances, presents a special case for "rational" suicide. *See, e.g.*, Siegel, *Rational Suicide: Considerations for the Clinician*, 54 Psychiatric Quarterly 77, 78 (1982) ("We need not argue the issue whether it is rational for an individual with painful terminal illness to refuse extraordinary life-saving measures or to more actively arrange to end his life. Most would agree it is rational."); Quill, *Physician-Assisted Death: Progress or Peril?*, 24 Suicide and Life-Threatening Behavior 315 (1994).[8] Moreover, research on suicide among the

[7](...continued)
upon objective criteria measured prior to the suicide, estimates of the correlation with mental illness were much lower (5%-22%). Temoche et al., *Suicide Rates Among Current and Former Mental Institution Patients*, 138 J. Nervous and Mental Disease 124 (1964).

[8] In one survey of 39 HIV-positive individuals, researchers concluded that more than two thirds had rationally contemplated suicide. Moreover, the desire to hasten death was not directly related to clinical depression

(continued...)

terminally ill must be interpreted with caution, because the cases likely to be studied are those that can be readily identified as "suicides," whereas other research indicates that many hastened deaths among terminally ill patients are never documented as such. S. Jamison, *Final Acts of Love: Families, Friends, and Assisted Dying* 5-6 (1995); R. Ogden, *Euthanasia, Assisted Suicide, and AIDS* 71-83 (1994). As a result, the research cited by opponents of hastened death must be viewed within an appropriately restrictive context, and it must be realized that it may not be possible to generalize the results. Several of the Coalition members listed in Appendix A have experience with literally hundreds of individuals who have died of terminal illnesses, and each could relate numerous stories of assisted deaths that were not reported as suicides. These professionals and the others who are members of the Coalition have chosen to join in this submission in part because their work has convinced them that the assertion that anyone, including terminally ill individuals, who wishes to hasten his or her own death must be depressed or otherwise mentally impaired is simply not borne out by either research or experience.

Recent research has found that a significant percentage of mental health professionals believe that hastening death can be a reasonable choice, and even have experience working with individuals who have made such decisions. In a national survey of a random sample of members of the American Psychological Association's Division of Psychotherapy, 81% of the respondents (with a 50% response rate) stated that they believed that an individual

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[5](...continued)
as measured by the Beck Depression Inventory (the most widely accepted means of making swift diagnoses of depression). Jones and Dilley, *Rational Suicide and HIV Disease*, 8 Focus: A Guide to AIDS Research and Counseling 5 (July 1993).

could make a rational decision to control the time and manner of his or her own death. Werth and Liddle, *Psychotherapists' Attitudes Toward Suicide*, 31 Psychotherapy: Theory, Research and Practice 440 (1994). In another study, using a sample of psychologists who were members of the National Register of Health Care Providers in Psychology, 86% of the respondents (again with a 50% response rate) indicated that they believed in rational suicide. J. Werth, *supra*, at 47. Twenty percent of the participants in the latter study stated that they had worked with patients whose hastened deaths could be considered "rational" suicides in the sense described above. J. Werth, *supra*, at 53; *see also* Pope et al., *Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists*, 42 Am. Psychologist 993, 1003 (1987).

Similar results have been found in surveys of psychiatrists. One study of physicians in Washington State found that of five categories of physicians, "psychiatrists were most supportive of" assisted suicide and euthanasia. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89, 91-92 (1994) (especially graphs). A more recent report found that two-thirds of the respondents to a survey of Oregon psychiatrists (with a 77% response rate) "endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for a medication whose sole purpose would be to allow a patient to end his or her life." Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 Am. J. Psychiatry 1469, 1469 (1996).

For these reasons, we think it must be accepted that a decision by a terminally ill patient to hasten his or her own death may be carefully considered and fully rational — just as it may be ill informed or the product of impaired

reasoning. Given the opportunity, mental health professionals are capable of assessing the nature and quality of a patient's decision-making process, and therefore of helping to determine that any decision that is implemented is a product of the patient's knowing and intelligent choice.

The decisions below would permit, perhaps for the first time, a process of free and open discussion and consultation among patients, their physicians, and mental health professionals concerning all end-of-life options. Indeed, States could and should, in our view, require such consultation in any case in which the patient's ultimate choice is to select or hasten the moment of death.[9] The mental health professionals involved would be in a position to assess the accuracy of the patient's understanding of his or her medical condition, including the prognosis and treatment alternatives; to review the quality of the patient's deliberative process; and therefore to evaluate the psychological soundness of his or her final choice. Under proper circumstances, a choice to control the manner and

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[9] Oregon's "Death With Dignity Act," for example, adopted by the State's voters on November 6, 1994, requires a physician to refer a patient who requests aid in dying to counseling if the physician believes that the patient may be depressed or otherwise mentally compromised. 1995 Or. Laws Ch. 3 (I.M. 16). The counseling is to consist of consultation with a licensed psychiatrist or psychologist to determine whether the patient is suffering from a psychiatric or psychological disorder, or from depression causing impaired judgment. We note that other mental health professionals, including social workers and professional counselors, who have appropriate training or experience in working with the terminally ill would also be capable of performing such evaluations. *See also* Baron et al., *A Model State Act to Authorize and Regulate Physican-Assistance Suicide*, 33 Harv. J. on Legis. 1 (1996), which proposes a specific series of procedural requirements designed to prevent mistaken decisions. In particular, the model act requires a review of the patient's competence by suitably trained mental health professionals.

hasten the time of death is neither inherently irrational nor indicative of mental illness. Rather, such a choice may be the final expression of a terminally ill patient's individual autonomy.

C. Assessing the Voluntariness of a Decision

The mental health professionals who work with terminally ill patients are as concerned as others that those patients who decide to hasten their own deaths make that decision free of any form of coercion or undue influence. They are equally concerned that a patient's choice may be merely impulsive, or that the patient may be so ambivalent that the simple passage of time is likely to change his or her mind. *See, e.g.*, Am. Cur. Br. for the ASF 9-10. Although these dangers are real, they may largely be avoided by appropriate state regulation of the process by which such individuals request and receive physician assistance, including mandatory waiting periods and the involvement of mental health professionals in the sorts of evaluations and counseling described above.[10] This may be accomplished without, at the same time, denying patients who are in a position to make free, informed, and intelligent decisions the opportunity to do so. Indeed, the active and open involvement of mental health professionals in counseling terminally ill patients about end-of-life issues may well be the best guarantee that *all* such patients will have the

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[10] For example, Section 3 of the proposed *Model Act to Authorize and Regulate Physician-Assisted Suicide* also contains requirements that "the request must be competent, fully informed, voluntary, and enduring." *See* Baron, *supra* note 8, at 26. The proposed statute also mandates that a professional mental health care provider "evaluate the patient to determine that his or her decision is fully informed, free of undue influence, and not distorted by depression or any other form of mental illness." *Id.* at 18.

information and support necessary to make their own decisions, based on their own values, about the course of their own treatment and, ultimately, their own manner of dying.

Assessments of whether a particular decision reflects independent determination or improper outside influence, like assessments of capacity to make reasoned decisions, are as familiar to mental health professionals as they are to the law. Mental health professionals are used to working, in a wide variety of contexts, with individuals who may be susceptible to pressure, suggestion, or intimations of authority. With a strong commitment to patient autonomy as a guiding principle, mental health professionals are uniquely suited to serve as counselors and advocates for terminally ill patients to protect against any improper pressure on this most sensitive of decisions. That is true whether the pressure in question arises from physicians, hospital administrators, third-party payers or "managed care" controllers, family members, or other inappropriate or treatable sources such as clinical depression, feelings of worthlessness, transient mental disorders, the effects of alcohol or other drugs, financial concerns, inadequate palliative care, or a lack of social support.

Concerns with respect to voluntariness and the risk of coercion apply equally in the case of terminally ill individuals who refuse, or request the discontinuation of, life-sustaining treatment. Those choices have nonetheless been made available to patients, under whatever safeguards individual States have deemed appropriate. Indeed, it is possible that recognition of the right at issue in these cases, together with the sort of independent counseling requirements that the States might be expected to enact in this context, would increase the level of information and support available to *all* patients, and thereby actually

decrease the number who choose to end their own lives. In any event, open discussion of end-of-life issues, and active involvement by mental health professionals, would significantly enhance confidence that any patient who requests assistance in hastening the end of his or her life does so as a matter of free choice.[11]

* * *

Recognition of a right to physician assistance in dying might well decrease those suicides that are of greatest legitimate concern to the State. Frank discussion of end-of-life issues between terminally ill patients, their treating physicians, and appropriate mental health professionals would necessarily raise the issues of capacity to make reasoned decisions, rationality, adequate information, exploration and availability of alternatives, and voluntariness discussed in this brief. Informed exploration of those issues might lead to the provision of appropriate treatment where all available methods have not been tried, and to the prevention of irrational and coerced deaths by those

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[11] With or without legal sanction, and with or without active or tacit professional assistance, some number of terminally ill patients already make their own decisions about exactly how and when to end their lives. One important effect of a decision affirming the judgments below might be to remedy an inequality akin to, but different from, that identified by the Second Circuit in *Quill*: the inequality between those patients who already have, whether through wealth, personal acquaintance, or mere physical ability, the de facto "right" to choose the time and manner of ending their battle with illness, and those whom disadvantage or disability consigns to live or die based solely on the medical and moral judgments of others. From the point of view of patient autonomy, surely it would be better to create a system under which some who have the power to die would receive the support or counseling that might convince them to live, while those who would truly choose to hasten their own ends would have the opportunity to do so without regard to fundamentally inconsequential criteria such as poverty or physical disability.

individuals who are not competent or rational (and whom the State has the greatest interest in protecting).

Similarly, because it is generally not legal to assist a patient to die, patients who wish to control their own deaths often reflect and act alone, without the benefit of counseling. They often believe that they must protect others by killing themselves in isolation, or earlier than they might otherwise choose, so they can be sure that they will still be able to carry out their own decision; or they may involve significant others, while feeling torn because doing so puts those individuals at risk both legally and emotionally. In either case, the results are often tragic. S. Jamison, *supra*, at 120-54; R. Ogden, *supra*, at 89-90. Drugs taken to hasten death, for instance, may not be properly absorbed, putting the patient at risk of further disability or prolonged suffering as a result of liver or kidney failure. Significant others may then be forced to become deeply involved. In desperation, they may even resort to violent measures, in which case the resulting post-traumatic stress compounds the tragedy. Holtby, *Social Work, Suicide, and Self Deliverance, in* 1 National Social Work AIDS Network Readings and Writings No. 3, 30 (1996). The availability of legal, regulated means for seeking assistance in dying, including the involvement of mental health professionals, would reduce these problems, and would allow professionals to deal openly with issues of emotional closure with a patient's family and helping the family to support the suffering individual. *See, e.g.*, Lester, *Easing the Legacy of Suicide: Counselor Assisted Suicide, in* Changes (forthcoming 1997); J. Werth, *supra*, at 100. Protection of the public would thus be enhanced, not diminished, by bringing physician assistance in dying under the scrutiny of the law.

The process of discussion and counseling that should accompany any end-of-life decision often does lead patients

to choose some option other than assisted suicide — even if the patient actively considers that course as one possibility. In fact, anecdotal reports and some recent research suggest that giving some patients a credible option, or even the means, to hasten death if they decide to do so in the future may decrease the patient's desire to die immediately, and even enhance the quality of the patient's remaining life, thus reducing the risk that a patient will act impulsively or prematurely. *See* Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996); Block and Billings, *supra*, at 2045; *See* M. Battin, *The Death Debate-Ethical Issues in Suicide* 202 (1996), *quoting* C. Owens et al., *Cancer Patients' Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia*, 3 Psycho-Oncology 1 (1994). It is worth emphasizing that the cases before this Court involve what is presently, and is likely to remain, a minority of patients who reach a carefully considered decision to hasten the end of life, even after a thorough exploration of the alternatives.

As mental health professionals, we have no interest in "promoting" assisted suicide. Our interest lies, instead, in the promotion of patient autonomy, balanced by concern for the welfare and protection of the public, and in the sound development of the law to that end.

CONCLUSION

The judgments of the courts of appeals should be affirmed.

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Dated: December 10, 1996

APPENDIX A

Coalition of Mental Health Professionals Supporting Individual Self-Determination in Decisions to Hasten Death

Individuals' affiliations are provided for identification only. The views expressed are those of individual coalition members and not necessarily those of any institution or organization with which they may be affiliated.

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APPENDIX B

National Association of Social Workers
Policy Statement

Client Self-determination in End-of-Life Decisions

BACKGROUND

End-of-Life decisions are the choices made by a person with a terminal condition regarding his or her continuing care or treatment options. These options may include aggressive treatment of the medical condition, life-sustaining treatment, palliative care, passive euthanasia, voluntary active euthanasia, or physician-assisted suicide. For the purposes of this policy statement, these terms are defined as follows:

Terminal and irreversible condition means a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness, which, within reasonable medical judgment, would produce death within a short time and for which the application of life-sustaining procedures would serve only to postpone the moment of death. There is no universally accepted definition of "a short time," but in general it is considered to be less than one year (American Hospital Association, 1991).

Client self-determination means the right of the client to determine the appropriate level, if any, of medical intervention and the right for clients to change their wishes about their treatment as their condition changes over time or during the course of their illness. Self-determination assumes that the client is mentally competent.

Incompetent means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.

Advance health care directive is a document in which a person either states choices for medical treatment or designates who should make treatment choices if the person should lose decision-making capacity. Although the term "advance directive" generally refers to formal, written documents, it may also include oral statements by the patient (American Hospital Association, 1991).

Life-sustaining treatment is medical intervention administered to a patient that prolongs life and delays death (American Hospital Association, 1991).

Medically inappropriate life-sustaining procedures means life-sustaining procedures that are not in accord with the patient's wishes or that are medically futile.

Palliative care is medical intervention intended to alleviate suffering, discomfort, or dysfunction but not to cure (American Hospital Association, 1991).

Passive euthanasia is the withholding or withdrawing of life-sustaining treatment. It is the forgoing of treatment, sometimes called "letting die." The right-to-die rulings such as in the Karen Ann Quinlin case establish the right under certain circumstances to be disconnected from artificial life support.

Voluntary active euthanasia is a physician's administering a lethal dose after a clearly competent patient makes a fully voluntary and persistent request for aid in dying. This is the active termination of a patient's life by a physician at the request of the patient.

Physician-assisted suicide is a patient's ending his or her life with the means requested of and provided by a physician for that purpose. The physician and the patient are both involved. Nurses or significant others may also be involved, but the physician has the responsibility for

providing the means. In all cases, the patient will have been determined competent to make such a decision.

Some argue that little distinction exists between euthanasia and physician-assisted suicide other than mechanical or technical difference as to who—the patient or the physician—triggers the event. Others (for example, Quill, 1991) maintain the difference is significant in that in assisted suicide the final act is the patient's; the risk of subtle coercion from doctors, family, or other social forces is reduced; the balance of power between patient and physician is more equal; and there is less risk of error, coercion, or abuse.

There has been a proliferation of state legislation related to assisted suicide, including Washington State's "Death with Dignity" initiative, which was narrowly defeated in a referendum in 1991, and bills that were in progress in 1993 in the California, Iowa, Maine, Michigan, and New Hampshire state legislatures. (The Michigan bill required social work counseling to qualified applicants for assisted suicide.) Currently, 37 states outlaw actively helping a patient to die (Brody, 1992).

The Patients' Self-Determination Act of 1990, included in the Omnibus Budget Reconciliation Act of 1990, requires all hospitals participating in Medicare or Medicaid to ask all adult inpatients if they have advance directives, to document their answers, and to provide information on state laws and hospital policies. Other health agencies such as home health and hospice have instituted similar requirements (American Hospital Association, 1991). In many of these facilities, social workers are called on to work with patients regarding advance health care directives and end-of-life decisions.

ISSUE STATEMENT

Advances in medical capabilities and technology have made it possible to extend life through artificial means that were heretofore unimaginable. Although this level of care often provides enormous benefits for patients, it may also present difficult and increasingly complex ethical choices for patients, their families, and health care professional. Inappropriate or unwanted utilization of medical technology may lead to lessened quality of life, loss of dignity, and loss of integrity of patients.

State and federal legislation related to advance health care directives has raised public awareness about the right of patients to participate in medical decision making, including end-of-life decisions. The individuals most immediately facing end-of-life decisions are those with a terminal and irreversible condition, a progressive chronic illness, or chronic intractable pain.

As advocates for the rights of individuals; as providers of mental health services; and as workers in hospitals, hospices, nursing homes, and crisis centers, social workers regularly deal with quality-of-life issues and choices related to life and death. Social workers have requested guidelines that are compatible with professional and personal ethics, legal parameters, and respect for client self-determination. Furthermore, other professionals look to social work for guidelines on these complex issues:

> Social work values, our traditional role as advocates and enablers, and our self-awareness and conscious use of self should serve as justification for engaging people in open and honest debate, recognizing the biases that society and the health care system have had with respect to the backgrounds, lifestyles, and illness of different groups of patients . . . . The social work community has the opportunity and the obligation to educate, organize, and advocate for a more widespread and extensive debate of these life and death matters. (Mizrahi, 1992)

In acknowledging and affirming social work's commitment to respect diverse value systems in a pluralistic society, end-of-life issues are recognized as controversial because they reflect the varied value systems of different groups. Consequently, the National Association of Social Workers (NASW) does not take a position concerning the morality of end-of-life decisions, but affirms the right of the individual to determine the level of his or her care.

It is also recognized that de facto rationing of health care based on socioeconomic status, color, ability to pay, provider biases, and government policy differentially affects people's right to choose among viable service alternatives and their ability to give truly informed consent. The social worker should work to minimize the effect of these factors in determining the care options available to individuals:

In examining the social work role in working with clients around end-of-life decisions, the following issues must be addressed:

- the legal parameters that affect social work practice (for example, limits of confidentiality, state laws prohibiting assisted suicide, the potential for civil liability)
- the potential conflict of social work values with those of other health care professionals
- the emerging pressures for cost control and rationing of healthcare (for example, temptation of health care institutions and insurers to encourage use of end-of-life practices to control costs)

- the possibility of patients feeling obliged to choose death rather than becoming a burden (Brock, 1992)
- the societal limits on individual self-determination and autonomy
- the necessity to define safeguards to protect individual and society in the implementation of end-of-life practices

POLICY STATEMENT

NASW's position concerning end-of-life decisions is based on the principle of client self-determination. Choice should be intrinsic to all aspects of life and death.

The social work profession strives to enhance the quality of life; to encourage the exploration of life options; and to advocate for access to options, including providing all information to make appropriate choices.

Social workers have an important role in helping individuals identify the end-of-life options available to them. This role must be performed with full knowledge of and compliance with the law and in accordance with the *NASW Code of Ethics* (NASW, 1993). Social workers should be well informed about living wills, durable power of attorney for health care, and legislation related to advance health care directives.

A key value for social workers is client self-determination. Competent individuals should have the opportunity to make their own choices but only after being informed of all options and consequences. Choices should be made without coercion. Therefore, the appropriate role for social workers is to help patients express their thoughts and feelings, to facilitate exploration of alternatives, to provide information to make an informed choice, and to deal with grief and loss issues.

Social workers should not promote any particular means to end one's life but should be open to full discussion of the issues and care options. As a client is considering his or her choices the social worker should explore and help ameliorate any factors such as pain, depression, need for medical treatment, and so forth. Further, the social worker should thoroughly review all available options including, but not limited to, pain management, counseling, hospice, nursing home placement, and advance health care directives.

Social workers should act as liaisons with other health care professionals and help the patient and family communicate concerns and attitudes to the health care team to bring about the most responsible assistance possible.

Because end-of-life decisions have familial and social consequences, social workers should encourage the involvement of significant others, family, and friends in these decisions. social workers should provide ongoing support and be liaisons to families and support persons (for example, caregivers, significant others) with care to maintain the patient's confidentiality. When death occurs, social workers have an obligation to provide emotional and tangible assistance to the significant others, family, and friends in the bereavement process.

Social workers should be free to participate or not participate in assisted-suicide matters or other discussions concerning end-of-life decisions depending on their own beliefs, attitudes, and value systems. If a social worker is unable to help with decisions about assisted suicide or other end-of-life choices, he or she has a professional obligation to refer patients and their families to competent professionals who are available to address end-of-life issues.

It is inappropriate for social workers to deliver, supply, or personally participate in the commission of an act

of assisted suicide when acting in their professional role. Doing so may subject the social worker to criminal charges. If legally permissible, it is not inappropriate for a social worker to be present during an assisted suicide if the client requests the social worker's presence. The involvement of social workers in the assisted suicide cases should not depend on race or ethnicity, religion, age, gender, economic factors, sexual orientation, or disability.

NASW chapters should facilitate their membership's participation in local, state, and national committees, activities, and task forces concerning client self-determination and end-of-life decision. Education and research on these complex topics should be included in the social work role.

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Supreme Court of the United States
OCTOBER TERM, 1996

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On Writs of Certiorari to the
United States Court of Appeals
for the Ninth and Second Circuits

BRIEF *AMICUS CURIAE* OF JULIAN M. WHITAKER, M.D. IN SUPPORT OF RESPONDENTS

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IN THE
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STATE OF WASHINGTON, *et al.*,
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On Writs of Certiorari to the United States Court of Appeals for the Ninth and Second Circuits

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BRIEF *AMICUS CURIAE* OF JULIAN M. WHITAKER, M.D. IN SUPPORT OF RESPONDENTS

INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, Julian M. Whitaker, M.D. ("Dr. Whitaker"), respectfully submits this brief in support of Respondents in *State of Washington v. Glucksberg*, No. 96-100, and *Vacco v. Quill*, No. 95-1858.[1]

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[1] Dr. Whitaker has received the written consent of the Petitioners and Respondents in both cases. Those letters of consent have been filed with the Clerk of the Court.

Dr. Whitaker is a physician licensed to practice medicine in the states of California and Washington.[2] He is the Clinical Director of The Whitaker Wellness Institute in Newport Beach, California and the editor of *Health & Healing*, the nation's largest single editor health newsletter with approximately 500,000 subscribers.[3]

Many of those whom Dr. Whitaker treats are geriatric patients who suffer from chronic and debilitating illnesses. A minority of those patients are terminally ill in the latter stages of disease. Of those, a few suffer from severe and persistent pain despite the administration of higher dosage levels of appropriate pain relieving drugs. For them, a stark question inevitably arises: Are the moments of consciousness accompanied by severe and persistent pain worth enduring if no cure is possible and if time brings with it only more pain, greater need for pain medication, side effects from that medication, new kinds of pain from the progression of the disease, less freedom and personal dignity, and greater incapacity? Each person in this category will answer that question differently. Answers depend on each person's deeply held personal values and beliefs, unique life expereince, and unique tolerance for pain. Some will choose to endure until the disease conquers life by robbing every vital sign. Others will choose to end their agony by either (1) discontinuing life-sustaining treatment, (2) consuming lethal doses of pain killing medication, or (3) consuming other drugs that have the effect of ending life. Your *amicus* believes it neither morally appropriate nor consistent with this Court's prece-

[2] Dr. Whitaker graduated from Dartmouth College in 1966 with a B.S. degree and Emory University in 1970 with an M.D. degree. He received his formal training in surgery as a resident at the University of California Medical School and in medicine as a physician with the Pritikin Institute in California.

[3] Dr. Whitaker is the author of five books on age-related diseases: *Reversing Heart Disease* (1985), *Reversing Diabetes* (1987), *Reversing Health Risk* (1989), *Natural Healing* (1994), and *What Your Doctor Won't Tell You About Bypass* (1995).

dent for the Government to deny competent, terminally ill patients freedom to elect a humane, dignified, and prompt departure from life rather than an extended dying process robbed of value and dignity by severe pain and incapacity.

To be sure, consistent with this Court's precedent, the state retains the power to regulate the conditions under which those choices are exercised. The state cannot, consistent with the precedent protecting "bodily integrity" and "control" over "one's person," deny the choice altogether. In those rare and horrible circumstances when a competent patient's terminal illness is accompanied by severe, unrelenting pain for which relief is not possible,[4] that patient has a constitutional liberty right to maintain bodily integrity and personal control by ending life and avoiding further agony and indignity. It offends the core meaning of Fourteenth Amendment liberty for the state to force a patient to endure ever greater pain and incapacity until death results.

SUMMARY OF ARGUMENT

The Court has long recognized a right to "bodily integrity," a right to "control [of] one's person." *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 915 (1992) (Stevens J., concurring in part and dissenting in part) (citing *Rochin v. California*, 342 U.S. 165 (1952), and

[4] *See* American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474, 475 (1996):

> How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al reported that three of every four cancer patients have pain. Bonica's review of published reports indicates that more than half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

See also C.S. Cleeland, et al., *Pain and its Treatment in Out-patients with Metastic Cancer*, 330 New Eng. J. Med. 592 (1994).

Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942)). In these consolidated cases, the Court will decide whether that personal right is possessed by competent, terminally ill patients who elect to stop their pain and suffering by consuming life-ending medications. The Court will also decide whether there is any meaningful difference between death effected by a physician's cessation of life support and a physician's administration of palliative treatments,[5] on the one hand, and death effected by a physician's provision or prescription of life-ending medications, on the other.

Your *amicus* asserts that the right to bodily integrity, to control of one's person, protects the election of a competent, terminally ill person to stop his or her suffering through the ingestion of life-ending medications. Your *amicus* finds no principled basis for distinguishing between (i) cessation of life support, a legal alternative; (ii) administration of palliative treatments in doses known to be lethal, a legal alternative;[6] and (iii) provision or prescription of other life-ending medications, an alternative unlawful under the statutes here in issue. Any physician who would fulfill a patient's request for any one of the three modes of hastening death understands the probable outcome: death. By forbidding the third alternative, New York and Washington do not end physician-assisted suicide. Instead, they deny competent, terminally ill patients who wish to hasten death an essential option, one that avoids acts of self-inflicted violence, avoids a slow and painful demise through refusal of life-support, which causes starvation or suffocation, and avoids the incursion of pain at ever higher thresholds until an overdose of pain medication is prescribed. By forbidding the option of physician-assisted suicide through provision or prescription of life-ending medication, New York and Washington deny the competent, terminally ill patient control over his or her bodily integrity. That denial renders each such person a prisoner of legal procedure, forced to endure pain and suffering beyond a threshold that he or she can tolerate. Your *amicus*, therefore, urges the Court to uphold the decisions below and to recognize the existence of a constitutional liberty right of the competent, terminally ill to end their pain and suffering through ingestion of life-ending medications.

[5] *See* Courtney S. Campbell, *Suffering, Compassion, and Dignity in Dying*, 35 Duq. L. Rev. 109, 112 (1996) ("It is common knowledge . . . that palliative care for pain and suffering tends to significantly diminish the number of patient requests for a hastened and assisted death") (citing Sidney H. Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New Eng. J. Med. 844, 846-48 (1989)).

[6] Physician administration of pain relieving medications is considered lawful even if death results from overdosing. *See* George J. Annas, *Death by Prescription—The Oregon Initiative*, 331 New Eng. J. Med. 1240 (1994); Norman Contor, et al., *Pain Relief, Acceleration of Death, and Criminal Law*, 6 Kennedy Inst. Ethics J. 107 (1996). *See also* Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A15.

ARGUMENT

I. COMPETENT, TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONAL LIBERTY RIGHT TO STOP THEIR SUFFERING THROUGH INGESTION OF LIFE-ENDING MEDICATIONS

There are few principles more embedded in our constitutional law than that "liberty" within the Due Process Clause of the Fourteenth Amendment ~~that have~~ has substantive as well as procedural meaning.[7] The Court has held that a

[7] As the Court explained in *Planned Parenthood v. Casey*, 505 U.S. 833, 846-847 (1992):

> Although a literal reading of the Clause might suggest that it governs only the procedures by which a State may deprive persons of liberty, for at least 105 years, since *Mugler v. Kansas*, 123 U.S. 623, 660-661 . . . (1987), the Clause has been understood to contain a substantive component as well . . . As Justice Brandeis (joined by Justice Holmes) observed, "[d]espite arguments to the contrary which had seemed to me persuasive, it is settled that the due process clause of the Fourteenth Amendment applies to matters of substantive law as well as to matters of procedure. Thus all fundamental rights comprised within the term liberty are protected by the Federal

liberty interest will be protected if it is "fundamental." A fundamental liberty interest is one "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if [it] were sacrificed," *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937); "so rooted in the traditions and conscience of our people as to be ranked as fundamental," *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (*see also Michael H. v. Gerald D.*, 491 U.S. 110, 122 (1989) (citing *Snyder*)); or "deeply rooted in this Nation's history and tradition," *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977). Direct burdens upon fundamental liberty interests are impermissible unless "the governmental entity imposing the restriction can demonstrate that the limitation is both necessary and narrowly tailored to serve a compelling governmental interest." *Planned Parenthood v. Casey*, 505 U.S. 833, 929 (1992) (citing *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965)). Such burdens will not withstand scrutiny if less drastic means exist for achieving the government's purpose. *See, e.g., Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

Although the Court cannot disregard a "relevant tradition protecting, or denying protection to, the asserted right," *Michael H. v. Gerald D.*, 491 U.S. 110, 127 (1989), neither can it apply historical precedent mechanistically because in times past right violations have in fact become

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Constitution from invasion by the States" [citing *Whitney v. California*, 274 U.S. 357, 373 (1927)].

See also Bowers v. Hardwick, 478 U.S. 186, 191 (1986):

> It is true that despite the language of the Due Process Clauses of the Fifth and Fourteenth Amendments, which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which those clauses have been interpreted to have substantive content, subsuming rights that to a great extent are immune from federal or state regulation or proscription. Among such cases are those recognizing rights that have little or no textual support in the constitutional language. *Meyer*, *Prince*, and *Pierce* fall into this category, as do the privacy cases from *Griswold* to *Casey*.

deeply rooted in our nation's history and condoned by a majority. *See, e.g., Loving v. Virginia*, 388 U.S. 1 (1967) (invalidating a law prohibiting miscegenation despite a long history of public acceptance); *Roe v. Wade*, 410 U.S. 113 (1973) (invalidating abortion proscription despite the fact that abortion was an illegal act at common law); *Brown v. Board of Education*, 347 U.S. 483 (1954) (invalidating racial segregation in schooling despite a long history of public and legal acceptance of that practice); and *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 69 (1976) (rejecting requirement of husband's consent for married women to obtain abortion despite common law limitations on women's legal rights and status).[8] Moreover, advances in technology can affect the scope of a liberty interest and, indeed, what is and what is not protected by the Due Process Clause.[9]

In defining the meaning of "liberty," the Court implores caution. It proceeds with due regard for precedents that define the scope of liberty already protected by the Constitution, because "[t]he Court is most vulnerable and

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[8] *See also O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty") and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 749, 789 (1986) (White, J., dissenting):

> The Constitution is not a deed setting forth the precise metes and bounds of its subject matter; rather, it is a document announcing fundamental principles in value-laden terms that leave ample scope for the exercise of normative judgment by those charged with interpreting and applying it. In particular, the Due Process Clause of the Fourteenth Amendment, which forbids the deprivation of 'life, liberty, or property without due process of law,' has been read by the majority of the Court to be broad enough to provide substantive protection against state infringement of a broad range of individual interests.

[9] *See Rochin v. California*, 342 U.S. 165, 171-172 (1952) ("To believe that this judicial exercise of judgment could be avoided by freezing 'due process of law' at some fixed stage of time or thought is to suggest that the most important aspect of constitutional adjudication is a function for inanimate machines and not for judges").

comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

In that regard, this Court has long recognized that the liberty right protects individual, life-affecting elections of the most personal nature: "Our cases have long recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986), *citing Carey v. Population Services International*, 431 U.S. 678 (1977); *Moore v. East Cleveland*, 431 U.S. 494 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923); and *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977). For example, this Court has recognized as fundamental and, so, beyond the government's reach, the right to bear or beget a child, *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); to establish a home and raise children, *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); to marry, *Loving v. Virginia*, 388 U.S. 1 (1967); to procreate, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); to use contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965); to direct the upbringing and education of a child, *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925); to decide independently, with the advice of a physician, to acquire and to use needed medication, *Whalen v. Roe*, 429 U.S. 589, 603 (1977); to avoid unwanted administration of antipsychotic drugs, *Washington v. Harper*, 494 U.S. 210, 221-222 (1990); and to refuse unwanted medical treatment, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 281 (1990). In each of these cases, the Court has protected "personal autonomy" from government deprivation. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 791 (1986) (White, J., dissenting).

In *Planned Parenthood v. Casey*, 505 U.S. 833, 847 (1992), reflecting upon this precedent, the Court wrote of a "realm of personal liberty which the government may not enter" that involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Id.* at 851. The Court found such choices to be "central to personal dignity and autonomy" and "central to the liberty protected by the Fourteenth Amendment." *Id.* Indeed, the Court explained that "the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.*

Constitutional liberty, this Court has already concluded, embraces personal, life-affecting decisions, such as the decision to abort a fetus or to refuse medical treatment:

> *Roe* [*v. Wade*] . . . may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection. If so, our cases since *Roe* accord with *Roe*'s view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990) . . . . see also, *e.g.*, *Rochin v. California*, 342 U.S. 165 (1952) . . . *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 . . . (1905).

Planned Parenthood v. Casey, 505 U.S. at 857.

Because "liberty" encompasses personal, life-affecting decisions such as whether to abort a fetus, to refuse unwanted drugs, or to refuse unwanted medical treatment necessary to sustain life, it would be illogical, and a radical departure from precedent, to hold that it does not also protect a competent, terminally ill patient's election to forego further suffering by ingesting a life-ending med-

ication. The Court's personal liberty rationale for protecting the right to abort and the right to refuse treatment applies with equal validity to a competent, terminally ill person's election to ingest life-ending medication.

In most instances, the constitutionally protected refusal of hydration, feeding, and artificial respiration brings on a slow, agonizing death: starvation or suffocation. The practice of escalating pain medication until death results (also widely condoned by law) is another slow and painful approach. The methods are, however, indistinguishable in ultimate effect from the provision or prescription of life-ending medication. It would therefore offend this Court's precedent, and basic logic, to deny constitutional protection for physician-assisted suicide in the case of competent, terminally ill persons.

A. Historic Antecedents to the Right to Bodily Integrity and to Control of One's Person

The understanding of "liberty" that originally animated the Fifth Amendment, and later came to be the core understanding of the Fourteenth Amendment, arose in the seventeenth and eighteenth centuries with the opposition political movement to the Hanoverian Kings (the so-called "Radical Whigs") and held sway in the colonies and with the original founders.[10] The revolutionary legislators

[10] *See* Bernard Bailyn, 1 Pamphlets of the American Revolution *1750-1776* 28-29 (1965); Steven J. Heyman, *The First Duty of Government: Protection Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 516 (1991) (. . . a small group of radical Whig opposition writers . . . had a crucial impact on the development of American political thought in the decades leading up to the Revolution"). Two Radical Whigs, Thomas Gordon and John Trenchard, were most notable in the American colonies for their collection of 138 essays on civil and religious liberty that were published in book form and entitled *Cato's Letters*. First published serially in *The London Journal* from 1720 to 1723, the essays were republished as books and went through six editions between 1723 and 1755. Historian Bernard Bailyn writes:

> Republished entire or in part again and again in the colonies, "quoted in every colonial newspaper from Boston to Savannah," and referred to repeatedly in the pamphlet literature, the writings of Trenchard and Gordon ranked in the minds of the Americans with treatises of Locke as the most authoritative statement of the nature of political liberty and above Locke as an exposition of the social sources of the threats it faced.

Bernard Bailyn, 1 *Pamphlets of the American Revolution 1750-1776* 30 (1965). Historian Forrest McDonald notes that *Cato's Letters* were "widely read by American patriots." F. McDonald, *Novus Ordo Seclorum* 47 (1985). Historian Jeffrey Smith finds that *Cato's Letters* "were immensely popular in America, where journalists and political theorists praised and imitated the authors." Jeffrey Smith, *Printers and Press Freedom* 25 (1988).

of the newly formed states gave legal force to these conceptions of liberty by rendering them among the "inalienable" rights protected under the original state constitutions.[11]

As for the meaning of "liberty" pertinent to medical treatment, the Radical Whigs Trenchard and Gordon defined the term in words similar to those later chosen by Justice Brandeis.[12] Gordon and Trenchard believed liberty a right "to live upon one's own terms."[13] With particular pertinence to government regulation of suicide, Trenchard and Gordon wrote:

> But whilst Men have their five Senses, I cannot see what the Magistrate has to do with Actions by which the Society cannot be affected; and where he meddles with such, he meddles impertinently or tyrannically. Must the Magistrate tie up every Man's Legs, because some Men fall into Ditches? . . . . Or, would it become the Wisdom and Care of Governors to establish a travelling [sic] Society, to prevent People, by

[11] *See* ROBERT RUTLAND, *The Birth of the Bill of Rights, 1776-1791* 42 (1983).

[12] Justice Brandeis considered the "liberty" right a "right to be let alone." *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

[13] 1 *CATO's Letters* 249 (L. Levy ed., Reprint 1971).

> proper Confinement, from throwing themselves into Wells, or over Precipices; Or to endow a Fraternity of Physicians and Surgeons all over the Nation, to take Care of their Subjects Health, without being consulted; and to vomit, bleed, purge, and scarify [sic] them at Pleasure, whether they would or no, just as these established Judges of Health should think fit? If this were the Case, what a Stir and Hubbub should we soon see kept about the established Potions and Lancets . . . Let People alone, and they will take Care of themselves, and do it best . . .

1 *CATO's Letters* 247 (L. Levy, ed. 1971).

Thus, strong conceptions of personal autonomy and freedom from restraint (even restraint against suicide) were deeply rooted in our historic understanding of "liberty"—a legacy of the eighteenth century Radical Whigs. Additional meaning for the term "liberty" came from Coke, Blackstone, and Locke but "[w]hat integrated all these sources into a coherent world view for Americans, as Bernard Bailyn and Gordon Wood have shown, was radical Whig ideology." [14]

Coincidental with the popular and political definitions of "liberty" communicated by the Radical Whigs were the eighteenth and nineteenth century legal understandings of the term derived from Chapter 29 of the Magna Carta.[15] In his *Commentaries on the Laws of England*, William Blackstone defined certain liberty rights as "abso-

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[14] *See* Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 521 (1991).

[15] Chapter 29 of the Magna Carta provides: "No freeman shall be taken, or imprisoned, or be disseised of his Freehold, or Liberties, or free Customs, or be outlawed, or exiled, or any otherwise destroyed; nor will [the sovereign] pass upon him, nor condemn him, but by lawful Judgment of his Peers, or by the Law of the Land." Magna Carta ch. 29 (1225) (Eng.), 1 Stat. at Large 7-8 (London, 1763).

lute" and others as "relative." [16] The absolute rights included those to "personal security, personal liberty, and private property." [17] "Personal security" included "a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." [18] "Personal liberty" included freedom of movement "without imprisonment or restraint, unless by due course of law." [19] "Private property" included "the free use, enjoyment, and disposal of all [one's] acquisitions, without any control or diminution, save only by the laws of the land." [20]

In America, the rights to "personal security, personal liberty, and private property" became those to "life, liberty, and property" but carried much of the Blackstonian meaning. The protection of those rights for all Americans regardless of race was a principal aim of the Fourteenth Amendment.[21] As this Court has recognized repeat-

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[16] "Absolute rights were those that would belong to individuals in a state of nature. By contrast, relative rights were those that were 'incident to [persons] as members of society, and standing in various relations to each other.'" The "first and primary end of human laws' was 'to protect individuals in the enjoyment of [their] absolute rights'; the protection of relative rights was a secondary aim." Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 532 (1991) (quoting William Blackstone, 1 *Commentaries on the Laws of England* 123-124; 134; 422 (St. George Tucker ed., 1803 & photo reprint 1969)).

[17] William Blackstone, 1 *Commentaries on the Laws of England* 129 (St. George Tucker ed., 1803 & Photo reprint 1969); James Kent, 2 *Commentaries on American Law* 1-37 (1826); Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 532 (1991).

[18] William Blackstone, *Commentaries on the Laws of England* 129 (St. George Tucker ed., 1803 & photo reprint 1969).

[19] *Id.* at 134.

[20] *Id.* at 138.

[21] *See* Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507,

edly, the liberty right protected by the Fourteenth Amendment includes, at its core, the Blackstonian rights to personal security and personal liberty.[22]

The Court's recognition of a right to "bodily integrity" and "to control" of "one's person" [23] is in complete accord with the core meaning of the liberty right: the Blackstonian meaning (its barrier to state deprivation of "personal security" (*i.e.*, personal control over one's life, limbs, body, and health) and of "personal liberty" (*i.e.*, freedom from restraint)). So too is the Court's decision in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990) that "a competent person has a constitu-

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546-570 (1991). "[A]s the congressional debates indicate, when the Framers referred to 'life, liberty [and] property,' they principally mean the *rights* to life, liberty and property. They identified these rights with 'the absolute rights' of individuals recognized in the classical legal tradition: the rights to personal security, personal liberty, and private property." *Id.* at 561-562.

[22] *See Ingraham v. Wright*, 430 U.S. 651, 673-674 (1977) ("While the contours of this historic liberty interest in the context of our federal system of government have not been defined precisely, they always have been thought to encompass freedom from bodily restraint and punishment [citing *Rochin v. California*, 342 U.S. 165 (1952)]"); *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982) ("In the past, this Court has noted that the right to personal security constittues a 'historic liberty interest' protected subsantively by the Due Process Clause [citing *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)]"; *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part) ("Liberty from bodily restraints always has been recognized as the core of the liberty protected by the Due Process from arbitrary government action"); and *Sandin v. Conner*, 115 S.Ct. 2293, 2307 (1995) (Breyer, J., dissenting) ("In protecting liberty . . . the Due Process Clause protects . . . an absence of government restraint, the very absence of restraint that we call freedom").

[23] *Planned Parenthood v. Casey*, 505 U.S. 833, 915 (1992) (Stevens, J., concurring in part and dissenting in part) (citing *Rochin v. California*, 342 U.S. 165 (1952), and *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 585 (1942)).

tionally protected liberty interest in refusing unwanted medical treatment . . ."

The petitioners and certain of their *amici* call on the Court to sever from the right to bodily integrity an essential exercise of that right. On the one hand, petitioners laud protection of a terminal patient's election to end artificial life support but, on the other, they condemn protection of a terminally ill patient's election to ingest a life-ending medication. Their position is untenable in law and logic.

In both cases, it is the patient's desire to die and it is the physician's action that initiates a causal chain of events that logically results in death. In neither case, does "nature" take its course because there have been substantial artificial interventions: (1) the use of medical devices to infuse the body with life through artificial respiration, nourishment, and hydration and (2) the chronic use of cytotoxic drugs or pain killing medications to mask the very cruel "nature" of a cancer or other painful and terminal illness.

There is no principled distinction to be drawn between the two cases. The critical issue in both is whether the state has imposed a restraint upon bodily integrity that denies a terminally ill patient control over his or her person. A constraint that precludes a person's physician from ceasing life support to comply with a patient's wishes is of no material difference from one that precludes a person's physician from providing or prescribing a lethal dose of pain medication or a lethal dose of life-ending medication. In each case the liberty interest consists of the right to effectuate the terminally ill patient's desires to end suffering by hastening death. In each case, when the state intrudes to preclude effectuation of that desire, it invades the patient's bodily integrity, robs the patient of control over his or her person, and imposes its

command that the patient live in pain and incapacity on one who would rather end the ordeal.[24]

As Justice O'Connor presciently observed in *Cruzan*:

> A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion [citing *Washington v. Harper*, 494 U.S. 210, 221 (1990) and *Parham v. J.R.*, 442 U.S. 584, 600 (1979)].

497 U.S. at 288 (O'Connor, J., concurring).

B. The Common Law Prohibition on Suicide Does Not Define "Liberty" and Is Anachronistic

The petitioners and some of their *amici* contend that the Court should not recognize a constitutional right to physician-assisted suicide because at common law in pre-revolutionary America suicide was unlawful.[25] The conclusion reached, however, does not follow, and petitioners' reliance upon the common law suicide prohibition is misplaced. The Fourteenth Amendment's "liberty" term has never before been defined with reference to physician-assisted suicide. In addition, the world view that originally led to a general condemnation of suicide was predicated on a mystical conception of illness, dying, and death that has since been supplanted by a modern scientific view and understanding of those conditions. If the Court ties "liberty" to the pre-revolutionary view, it will cause the Four-

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[24] *See generally* Sanford Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Calif. L. Rev. 857, 864, 868 (1992).

[25] *See generally* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*" 24 DUQ. L. REV. (1985); *Suicide: A Constitutional Right?—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261 (1996).

teenth Amendment to become an anachronism rather than a vital force capable of transcending the ages.[26]

Even if the history of the common law in pre-revolutionary America is credited as evidence of the meaning of "liberty" within the Fourteenth Amendment, the eighteenth century ban on all suicides is anachronistic. People of the eighteenth century could not discern whether illness was terminal, nor did they have any understanding of microbiology. Disease, dying, and death were shrouded in mystery. Disease, dying, and death were frequently attributed to acts of God or Satan.[27] In short, while in eighteenth century America the onset of illness and the

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[26] Oliver W. Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897): "It is revolting to have no better reason for a rule of law than that it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past."

[27] The patient of the eighteenth century lived in an age when medicine was in its infancy (not until the late nineteenth century did microbiology reveal a previously invisible world of pathological agents). *See* 1 COMPANION ENCYCLOPEDIA OF THE HISTORY OF MEDICINE 65 (W.F. Bynum & R. Porter, ed. 1993). Medicine of the eighteenth century could not accurately diagnose disease, relied heavily upon frequent "bleedings" and "purgings" to rid the body of "evil humors," rarely discerned the presence of terminal illness, could not inform the patient with any degree of confidence of the nature or extent of pain associated with disease progression, and could not predict within reason the likely time of the patient's demise. *See Id.* at 320 ("[I]n the eighteenth century sickness remained a mysterious and unavoidable event resulting from fate or divine retribution"; "[m]inisters and priests continued to participate in . . . folk-healing schemes, a fact attested to by *Primitive Physick*, a widely circulated health manual by the Methodist John Wesley (1703-91)"; and "[t]he disease process was still most commonly explained in terms of a febrile crisis within the body, involving a 'coction' of peccant matter, resolved by excretion of this matter through the body's pores or orifices"). There was no scientific way to adjudge the quality of life or longevity.

arrival of death were simply not understood (the people of the time believed mystical external forces governed fate and should not be tampered with by mortal man), in twentieth century America the onset of illness and the arrival of death are generally understood. Indeed, unlike in the eighteenth century, it is now possible to segregate from the universe of all diseases a specific and limited class of illness that remains incurable. We now know scientifically the diseases drugs can treat successfully and those they cannot. We can also generally predict the time and nature of death for the terminally ill.[28] Many of the mysteries surrounding disease, dying, and death are gone. To a far greater extent than ever before, modern medical technology influences each of the processes of life and dying. We live into our sixties, seventies, and eighties through artificial interventions, including xenobiotic drugs and medical devices, and we die when those interventions no longer succeed in stemming the onslaught of ever persistent disease.

Hence, a general public condemnation of suicide in a society where life and death were believed to be commanded by mystical and religious forces cannot reasonably support argument for a specific condemnation of the provision of prescription of life-ending medication in our time. Lacking a direct casual connection between the prerevolutionary common law condemnation of suicide and the meaning of the Fourteenth Amendment's "liberty"

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[28] For example, the Medicare hospice benefit is limited to persons whose physicians attest that the patient has "a terminal illness with a life expectancy of six months or less." Health Care Finance Administration, *Medicare Part B Reference Manual*, Revision 020, (Aug. 23, 1996). Only 15% of patients receiving hospice care under Medicare Part B are alive for six months or more; the median survival time is approximately thirty-six days. Nicholas Christakis, et al., *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172-178 (1996).

term, this Court has no proper foundation for construing the Fourteenth Amendment's "liberty" term to prohibit a competent, terminally ill patient's election to ingest life-ending medications. Instead, as it has done repeatedly in the past, the Court should look to the meaning intended for the "liberty" term in Anglo-American history before the adoption of the Fifth and Fourteenth Amendments (a meaning that embraces protection for "bodily integrity" and "control" of "one's person").

Unlike the restrictive definition urged upon the Court by the petitioners, the more enlightened definition gleaned from the history underlying the Fifth and Fourteenth Amendments has the benefit of being both "rooted in the traditions and conscience of our people," *Snyder v. Massachusetts*, 291 U.S. at 105, and "implicit in the concept of ordered liberty" as defined by this Court's precedent.

II. THERE IS NO COMPELLING STATE INTEREST TO JUSTIFY VIOLATION OF THE LIBERTY RIGHT

Certain *amici* supporting the petitioners have argued that life in the final days of existence with a terminal illness can be rendered bearable through the administration of pain killing medication. They argue that patients informed of means to treat pain are usually persuaded to forego hastening death. Moreover, they argue that cancer patients contemplating physician-assisted suicide may be victimized by relatives who seek an inheritance or physicians more concerned with conserving medical resources than tending to the needs of a dying person.

In fact, for a significant minority of the terminally ill, adequate pain relief is not possible. Furthermore, untoward influences from physicians and family members, albeit a genuine concern, are matters ripe for tailored state regulation. There is no reason to conclude that the less restrictive alternative of tailored state regulation (such as mandatory second opinions and psychiatric evaluations)

would be an inadequate alternative to proscription of the right.

A. For at Least 10% of Terminally Ill Patients Adequate Pain Relief Is Not Possible

It is indeed true that in the vast majority of cases the terminally ill can cope with their pain through most, if not all, stages of disease progression if appropriate palliative treatments are administered. But even optimistic estimates on the success of pain management admit that at least 10% of terminally ill patients suffer from uncontrollable pain.[29] It is for them that palliative treatments afford inadequate relief.[30]

Patients with cancer often have multiple pain problems. Cancer pain may be due to (1) tumor progression and related pathology (e.g., nerve damage), (2) operations and other invasive diagnostic or therapeutic procedures, (3) toxicities of chemotherapy and radiation, (4) infection, or (5) muscle aches when patients limit physical activity. The incidence of pain in patients with cancer depends on the type and stage of disease. At the time of diagnosis and at intermediate stages, 30 to 45 percent of patients experience moderate to severe pain. On average, nearly 75 percent of patients with advanced cancer have pain. Of cancer patients with pain, 40 to 50 percent report

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[29] *See, e.g.*, Susan S. Land & Richard B. Patt, *You Don't Have to Suffer* 67 (1994):

> A concerned and knowledgeable doctor, from any specialty, can help up to 90 percent of patients achieve good control of pain. This process can be time consuming through no fault of his . . . . The key is to accept in advance that rarely can a doctor get it right the first time.

[30] Perhaps in time research will offer a cure for the currently incurable diseases or a means to alleviate intractable pain in all cases. Until that time, however, a significant minority of terminally ill patients will continue to need an alternative to the escalation of pain and incapacity that precedes their demise.

it as moderate to severe, and another 25 to 30 percent describe it as very severe.[31]

There is a wide spectrum in pain types.[32] The level, degree, and nature of pain varies depending on the terminal illness. Dr. Kathleen Foley's research led her to conclude that 85% of patients with primary bone tumors, 52% of patients with breast cancer, 20% of patients with lymphoma, and 5% of patients with leukemia had pain, She also found that 78% of hospitalized cancer patients had pain due directly to tumor involvement, 50% had pain due to bone disease, 25% had pain due to nerve compression, and 19% had pain due to the treatments they were given.[33]

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[31] *See* Kathleen M. Foley, *Pain Sydromes in Patients With Cancer* (1978); C.S. Cleeland, et al., *The Prevalence and Severity of Pain in Cancer*, 50 CANCER 1913-1918 (1982); J. Bonica, 1 *Cancer Pain —The Management of Pain* 400-460 (2d ed., 1990).

[32] *See* Kathleen M. Foley, *The Treatment of Cancer Pain*, 313 New Eng. J. Med. 85 (1985).

[33] *See* Kathleen M. Foley, *The Treatment of Cancer Pain*, 313 New Eng. J. Med. 85-86 (1985). Dr. Foley identifies two general categories of pain: acute and chronic. Acute pain is associated with hyperactivity of the autonomic nervious system. Acute pain is subcategorized into pain that is cancer-related (*i.e.*, pain that gives rise to the initial cancer diagnosis) and pain that is treatment-related (*i.e.*, pain occurring after administration of cytotoxic chemotherapy drugs and radiation therapy). Chronic pain is defined as pain that persists longer than 6 months in which adaptation of the autonomic nervous system occurs. Chronic pain transforms the person by permanently impairing their functional ability, altering their personalities, and affecting their lifestyles. Chronic pain is subcategorized into those that are cancer-related, involving pain arising from progression of the disease, and pain that is independent from and pre-exists the cancer. Foley identifies a subgroup consisting of those whose acute or chronic pain is accompanied by preexisting chronic pain unrelated to their cancer and a subgroup consisting of patients with a history of drug addition and cancer-related pain for which palliative treatment is rendered exceedingly complex because of the need to control the addiction. Foley's fifth

While palliative treatments can eliminate pain in a substantial number of cancer and AIDS cases, there remain those for whom such treatments are inadequate. It is precisely those patients whose rights must be protected should they elect to ingest life-ending medications rather than fight an unwinnable battle.

B. There Are Numerous Less Restrictive and Fully Adequate Alternatives to Proscription of the Right

There can be no doubt that from time to time certain individuals possessed of malicious intent (whether family members, friends, or physicians) will exert an untoward influence on the terminally ill, urging them to make a decision for or against physician-assisted suicide that may not be the one the patient would make if fully possessed of independent reason. That problem, and, indeed, any other abuse of the right, can be remedied by tailored state regulation (*i.e.*, regulation having only an incidental effect on the exercise of the right). An argument that presupposes abuse of a right as a justification for suppressing it is a classic fallacy of logic.

Tailored regulation of means by which to effectuate fulfillment of a right (*i.e.*, indirect regulation) is not a violation of the right itself. This Court has upheld a considerable number and variety of regulations designed to foster independent judgment in those who contemplate abortion. *See, e.g., Planned Parenthood v. Casey,* 505 U.S. 833, 873-874 (1992).[34] The states are free to enact

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subgroup, consisting of acute and chronic pain suffered by cancer patients who are dying, include people affected by the decisions in the consolidated cases. These individuals, she notes, require a rapid escalation in analgesic drug therapy and efforts to address each of the various pain symptoms that arise as the varying kinds of pain all come to bear at once.

[34] In *Casey*, the Court elaborated upon the distinction between regulations that have an incidental effect on the exercise of a right and those that "strike at the right itself." The analogy has perfect application to the instant cases. The Court explained:

> As our jurisprudence relating to all liberties save perhaps abortion has recognized, not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right. An example clarifies the point. We have held that not every ballot access limitation amounts to an infringement of the right to vote. Rather, the States are granted substantial flexibility in establishing the framework within which voters choose the candidates for whom they wish to vote [Citations omitted].
>
> The abortion right is similar. Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause.

Casey, 505 U.S. at 874-875.

similar regulations that will foster independent judgment in competent, terminally ill patients who contemplate physician-assisted suicide.

CONCLUSION

For the reasons stated above, the judgments of *Glucksberg* and *Quill* should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,

Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE CENTER FOR REPRODUCTIVE LAW & POLICY AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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This *amicus curiae* brief is submitted in support of Respondents Glucksberg, *et al.* By letters filed with the Clerk of the Court, Petitioners and Respondents have consented to the filing of this brief.

INTEREST OF AMICUS CURIAE

The Center for Reproductive Law and Policy (CRLP), founded in 1992, is an independent, non-profit legal organization dedicated to ensuring that all women have access to safe and affordable reproductive health care. Through litigation, research, policy analysis and public education, CRLP protects the right and ability of women around the world to obtain the full range of reproductive health services including abortion, contraception and new reproductive technologies. During the past twenty years, CRLP attorneys have been counsel for the parties or *amici curiae* in nearly every Supreme Court case concerning reproductive liberty, including *Whalen v. Roe*, 429 U.S. 589 (1977), *Carey v. Population Services International*, 431 U.S. 678 (1977), *Colautti v. Franklin*, 439 U.S. 379 (1979), *Bellotti v. Baird*, 443 U.S. 622 (1979), *Harris v. McRae*, 448 U.S. 297 (1980), *H.L. v. Matheson*, 450 U.S. 398 (1981), *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), *Bolger v. Young Drug Products Corp.*, 463 U.S. 60 (1983), *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), *Bowen v. Kendrick*, 487 U.S. 589 (1988), *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), *Hodgson v. Minnesota*, 497 U.S. 417 (1990), *Rust v. Sullivan*, 500 U.S. 173 (1991), and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Because the court of appeals relied heavily on this Court's reproductive rights jurisprudence in invalidating Washington's assisted suicide statute as applied, *amicus* has a vital interest in the outcome of this case.

SUMMARY OF ARGUMENT

In holding that Washington's ban on assisted suicide as applied to terminally ill patients seeking medication to hasten death violates the Due Process Clause of the Fourteenth Amendment, the court of appeals relied heavily on this Court's decision in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), finding a terminally ill person's decision to seek medication to hasten death very similar to the abortion right reaffirmed in *Casey*. *See Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996) (en banc). While emphasizing the similarities between the two decisions, the court of appeals failed to recognize that there are also important differences that dictate the use of different standards of review, without affecting the outcome of the constitutional tests.

Both a woman's decision to choose abortion as well as a terminally ill person's decision to seek medication to hasten death are deeply personal, weighty choices concerning an individual's bodily integrity and autonomy, and therefore, receive protection under this Court's precedents. However, unlike the freedom at issue here, the decision to choose abortion also has deep connections to a woman's ability to shape her family life and her role in American society, enabling her to break free of stereotypes that deny her the "equal opportunity to aspire, achieve, participate in, and contribute to society based on [her] individual talents and capacities." *United States v. Virginia*, 116 S. Ct. 2264, 2275 (1996).

Although ignored by the court of appeals, the differences, coupled with a history of discrimination against women, justify a different standard of review, but do not support a different result. Indeed, this Court need not even

consider its abortion cases in deciding this case. Because the Washington statutes cannot be constitutionally applied to respondents under this Court's bodily integrity and autonomy precedents, including this Court's only decision concerning an individual's constitutionally protected freedom to hasten death, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), the judgment of the court of appeals must be affirmed.

This Court's recognition in *Cruzan* that an individual has a protected liberty interest in hastening death by terminating life-sustaining treatment also applies when a terminally ill patient is seeking medication to hasten death. The Constitution's protection of bodily integrity and autonomy does not only apply to the refusal of unwanted treatment. It also encompasses a patient's freedom to make decisions concerning one's body and one's course of medical treatment.

Under *Cruzan*'s balancing analysis, neither of the asserted state interests justifies Washington's absolute prohibition. Where, as here, a terminally ill patient decides to end his or her life in an effort to avoid intense pain and anguish, the state interest in protection of life must give way to that individual's bodily integrity and autonomy. Indeed, Washington recognizes, in the context of termination of life-sustaining treatment, that the interest in preserving life does not outweigh the individual's freedom to make decisions about his life and course of medical treatment.

Likewise, the State's legitimate interest in avoiding mistake and abuse does not support Washington's absolute prohibition. Identical pressures are at work where a patient seeks a physician's assistance in terminating life-sustaining treatment as are present when taking medication to hasten

death. Because Washington has decided that its legitimate interests do not support a prohibition on an individual's decision to terminate treatment necessary for life, the State's claim that regulatory measures will not safeguard against mistake and abuse is wholly unreasonable and fails to justify the flat ban at issue here.

ARGUMENT

I. THE DIFFERENCES BETWEEN THE LIBERTY INTEREST HERE AND *PLANNED PARENTHOOD V. CASEY* JUSTIFY DIFFERENT STANDARDS OF REVIEW, BUT DO NOT SUPPORT REVERSAL.

A. The Ninth Circuit Properly Recognized the Similarities Between the Liberty Interest Here and the Right to Choose Abortion, But Ignored The Important Differences.

Constitutional protection for a woman's decision to choose abortion and for a terminally ill patient's decision to hasten death -- either by seeking medication or terminating life-sustaining treatment -- finds support in this Court's decisions affording protection to personal autonomy and bodily integrity. Over a century ago, this Court recognized the fundamental importance of an individual's control over decisions concerning his or her body. As this Court explained, "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . ." *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

Since *Botsford*, a long and unbroken line of this Court's cases have afforded constitutional protection to an

individual's "most basic decisions about . . . bodily integrity." *Casey*, 505 U.S. at 849. *See, e.g., Riggins v. Nevada*, 504 U.S. 127 (1992) (overturning criminal conviction because defendant was forced to take antipsychotic drugs during the course of trial); *Cruzan*, 497 U.S. 261 (recognizing constitutional protection for an individual's decision to hasten death by terminating life-sustaining treatment); *Winston v. Lee*, 470 U.S. 753 (1985) (invalidating surgical removal of a bullet from a robbery suspect); *Rochin v. California*, 342 U.S. 165 (1952) (invalidating stomach pumping of criminal suspect in search for drugs). Contrary to the State's argument, these decisions not only protect the individual against forced bodily invasion by the government; they also protect an individual's freedom to make decisions concerning his or her body, including the decision affirmatively to seek desired medical treatment.

In *Casey*, this Court recognized that a woman's right to choose whether to obtain an abortion or carry her pregnancy to full term flows, in part, from these established constitutional principles of bodily integrity and autonomy. *See Casey*, 505 U.S. at 857 (noting that constitutional protection for the abortion decision is a "rule . . . of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on the power to mandate medical treatment or to bar its rejection"); *id.* at 927 (Blackmun, J., concurring in part and dissenting in part) ("compelled continuation of pregnancy infringes on a woman's right to bodily integrity"). Likewise, in *Cruzan*, eight members of this Court affirmed that the constitutional protections of bodily integrity and autonomy applied to an individual's decision to hasten death by terminating life-sustaining treatment. *See Cruzan*, 497 U.S. at 278-79; *id.* at 287-89 (O'Connor, J., concurring); *id.* at 304-12 (Brennan, J., dissenting); *id.* at 331, 339-43 (Stevens, J.,

dissenting). The same is true here. *See infra* § I.B.

But unlike the freedom in *Cruzan*, the right to choose abortion does not solely rest on bodily integrity and autonomy. The Constitution also protects the right to choose abortion because it is a part of the "private realm of family life that the state may not enter." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). Noting that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education," *Casey*, 505 U.S. at 851, this Court in *Casey* explained that "[t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Id.*

In finding that the Constitution's protection of personal privacy included the right to choose abortion, the Court emphasized two points. First, this Court recognized that the decision to choose abortion "is of the same character as the decision to use contraception," and the Constitution protects both choices "because they involve personal decisions concerning not only the meaning of procreation but also human responsibility and respect for it." *Id.* at 852, 853. Second, the Court stressed that women need to be free to choose abortion in order to shape their destiny and role in American society. As the *Casey* majority explained:

> [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by a woman with a pride that ennobles her

> in the eyes of others and gives the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

Id. at 852; *see also id.* at 856 ("The ability of women to participate equally in the economic and social life of the Nation have been facilitated by their ability to control their reproductive lives.").

These differences justify the stronger, more protective standard of review applicable in abortion cases, and distinguish the *Casey* standard from the balancing analysis applied by this Court in *Cruzan*. In *Casey*, recognizing that state regulation of the abortion choice is "doubly deserving of scrutiny," *id.* at 896, as it "touche[s] not only upon the private sphere of the family, but upon the very bodily integrity of the pregnant woman," *id.*, the joint opinion fashioned the two-pronged undue burden test to determine the validity of state statutes restricting a woman's right to choose abortion before viability.

Although different from the traditional form of strict scrutiny, the undue burden test requires courts to engage in heightened scrutiny of state abortion regulations, mandating a searching inquiry into both the purpose and effect of state abortion regulations. As the joint opinion explained, under the undue burden test, a statute is an unconstitutional limitation on a woman's right to choose abortion if it has

> the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends.

Id. at 877.

The two prongs of the undue burden test function together to ensure that the state does not impose unnecessary and arbitrary obstacles to a woman's decision to choose abortion before viability. Under the "effect" prong, an abortion regulation that imposes a substantial obstacle in the path of a woman's decision to choose abortion is invalid. Under this standard, a state's prohibition of abortion is, of course, unconstitutional. *Id.* at 846, 879. But the "effects" prong of the undue burden test also bars states from passing restrictive regulatory measures. State regulations that deter women from seeking abortions through burdensome restrictions on the right to choose abortion are unconstitutional. *See id.* at 893-94 (finding that husband-notification provision imposes an undue burden because it is "likely to prevent a significant number of women from obtaining an abortion. . . . We must not blind ourselves to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases.").

The *Casey* undue burden standard, however, does not limit the Constitution's protections to those laws that have the effect of imposing a substantial obstacle on a woman's right to choose abortion. Because of the higher threshold necessary to establish that an abortion regulation has the effect of imposing an undue burden on a woman's right to choose abortion,[1] the *Casey* joint opinion establishes a second limitation on state power to restrict abortion, recognizing that the "effect" test alone would not adequately protect the woman's right to choose. The "purpose" prong seeks to ensure that state regulation of abortion furthers legitimate state objectives -- such as enhancing and informing a woman's abortion decision -- not the impermissible end of hindering her choice. Even where it imposes no substantial obstacle on a woman's decision to terminate her pregnancy, a state regulation enacted with the illegitimate purpose of making abortions more difficult to obtain are invalid. *See Armstrong v. Mazurek*, 94 F.3d 566, 567 (9th Cir. 1996) (noting that "one proper inquiry" under *Casey*'s purpose prong "is whether 'the requirements serve no purpose other than to make abortions more difficult'") (quoting *Casey*, 505 U.S. at 901); *cf. Planned Parenthood v. Danforth*, 428 U.S. 52, 79 (1976) (invalidating ban on saline abortions as "an unreasonable or

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[1] By contrast, before *Casey*, any statute that imposed a non-de minimis burden on the right to choose abortion triggered strict scrutiny, requiring the state to prove that an abortion restriction was narrowly tailored to achieve a compelling state interest. *See id.* at 871; *City of Akron v. Akron Ctr. for Reproductive Health, Inc.*, 462 U.S. 416, 427 (1983); *Roe v. Wade*, 410 U.S. 113, 155 (1973). In adopting the undue burden test, the joint opinion noted that "[t]he very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted. . . . [T]he undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty." *Casey*, 505 U.S. at 876.

arbitrary regulation designed to inhibit . . . the vast majority of abortions after the first 12 weeks").

As in other areas of this Court's jurisprudence, determining whether an unconstitutional purpose is "the predominant factor motivating the legislature's decision," *Miller v. Johnson*, 115 S. Ct. 2475, 2488 (1995), requires a searching and rigorous inquiry into the totality of circumstances surrounding the legislative enactment. *See, e.g.*, *Bush v. Vera*, 116 S. Ct. 1941, 1951-1960 (1996) (plurality opinion); *Shaw v. Hunt*, 116 S. Ct. 1894, 1900-01 (1996); *Church of the Lukumi Babalu Aye v. City of Hialeah*, 113 S. Ct. 2217, 2227-2231 (1993); *Edwards v. Aguillard*, 482 U.S. 578, 586-89 (1987). As in these other areas, a long history of persistent state hostility to the abortion right justifies this rigorous examination of the purpose of state abortion laws.

This searching standard of review is necessary because only women bear the burdens of restrictive abortion laws. As this Court recognized in *Casey*, restrictive abortion laws deprive women alone of the freedom to make the deeply personal and private decision to choose to terminate a pregnancy, instead forcing them to undergo the serious bodily intrusions associated with childbirth. *See Casey*, 505 U.S. at 850-53, 857-59. *Casey* demands an especially careful review to ensure that these laws do not impose on women -- as they have throughout history -- the state's "own vision of [her] role," preventing her from shaping her "destiny . . . and her place in society." *Id.* at 852. This need to carefully scrutinize laws that single out women for burdens resonates with this Court's equal protection jurisprudence, *see Virginia*, 116 S. Ct. at 2274 ("skeptical scrutiny of official action denying rights or opportunities based on sex responds to volumes of history"); *J.E.B. v. Alabama ex rel. T.B.*, 114 S. Ct. 1419, 1433 (1994)

(Kennedy, J., concurring) (noting "strong presumption that gender classifications are invalid"), and reflects the need to overcome the continuing effects of our Nation's "long and unfortunate history of sex discrimination." *Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) (plurality opinion).[2]

Indeed, this Court in *Casey* invalidated the husband-notification provision precisely because it was predicated upon stereotypical assumptions about the wife's role as mother and homemaker, ratified in cases such as *Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130 (1873), and *Hoyt v. Florida*, 368 U.S. 57 (1962), and the husband's role as head and master of the family. *See Casey*, 505 U.S. at 896-97. This Court recognized that by giving husbands a way to compel their wives to bear children for them, the state had sought to embody into law "the common-law status of married women [that is] repugnant to our present understanding of marriage and of the nature of rights secured by the Constitution." *Casey*, 505 U.S. at 898. "A State may not give to a man that kind of dominion over his wife that parents exercise over their children." *Id.*

Because the strength of the state interests change over the course of a woman's pregnancy, *Casey*'s undue burden

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[2] As Justice Ginsburg noted only last Term:

> Through a century plus three decades and more of [our] history, women did not count among voters composing "We the People"; not until 1920 did women gain a constitutional right to the franchise. And for a half century thereafter, it remained the prevailing doctrine, that government . . . could withhold from women opportunities accorded men so long as any "basis in reason" could be conceived for this discrimination.

Virginia, 116 S. Ct. at 2275 (citations omitted).

test does not govern all challenges to statutes restricting abortion. Where the state restricts a woman's freedom to choose abortion after viability, the basic principles in place since *Roe v. Wade*, 410 U.S. 113 (1973), remain applicable. Although a state maintains some latitude to ban abortions after a physician determines that the fetus is viable, the state's interest in the protection of viable fetal life can never override a woman's substantial liberty interest in making medical choices about her life and health. *See Casey*, 505 U.S. at 879; *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986) (invalidating post-viability choice of method regulation because it failed to "require that maternal health be the physician's paramount consideration"); *Roe*, 410 U.S. at 164-65 (noting that state may not prohibit abortions after viability where "necessary . . . for the preservation of the life or health of the mother"); *Jane L. v. Bangerter*, 61 F.3d 1493, 1504 (10th Cir. 1995) (noting that "[t]he importance of maternal health is a unifying thread that runs from *Roe* to *Thornburgh* and then to *Casey*"), *rev'd on other grounds sub nom. Leavitt v. Jane L.*, 116 S. Ct. 2068 (1996) (per curiam).

In these circumstances, the woman's interest in making choices about her life and health trumps any state interest in preserving the potential life of a viable fetus. The State is not even permitted to balance the harms to a sick woman against the interest in the life of the viable fetus. Instead, the decision "must be left to the discretion of the individuals involved. Neither the legislature, nor the courts, has either the legal or the moral authority to balance the interests and the lives involved, and to make this decision." *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051, 1060 (S.D. Ohio 1995), *appeal docketed*, Nos. 96-3157, 96-3159 (6th Cir. Feb. 8, 1996); *see also In re A.C*, 573 A.2d 1235, 1237 (D.C. 1990) (en banc)

(overturning order requiring dying pregnant woman to undergo caesarean section delivery in an attempt to save fetus because "in virtually all cases the question of what is to be done is to be decided by the patient -- the pregnant woman -- on behalf of herself and the fetus"); *In re Baby Boy Doe*, 632 N.E.2d 326, 330 (Ill. Ct. App. 1994) (holding that "a woman's competent choice in refusing medical treatment as invasive as a cesarean section during her pregnancy must be honored, even in circumstances where the choice may be harmful to her [viable] fetus").

B. These Differences Do Not Support Reversal, Because Under *Cruzan*, A Terminally Ill Person Has A Substantial Constitutionally Protected Interest In Obtaining Medication To Hasten Death.

While a terminally ill person's deeply personal decision to hasten death differs, in certain respects, from the right to choose abortion or carry a pregnancy to full term, these differences do not support a different result, because the absolute prohibition at issue here is unconstitutional as applied under the standard set forth in *Cruzan*.[3] In *Cruzan*, this Court considered whether Nancy Cruzan, who was incompetent and in a persistent vegetative state following a car accident, had a liberty interest in refusing treatment that was necessary to keep her alive. In reaching its conclusion that Ms. Cruzan enjoyed a protected interest, this Court engaged in a narrow and focused contextual

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[3] Throughout this litigation, petitioners have urged the courts to apply the standard for a facial challenge set forth in *United States v. Salerno*, 481 U.S. 739 (1987). Petitioners have now wisely abandoned that position. Because the court of appeals invalidated the statute as applied, not on its face, *Salerno*, by its terms, has no application here.

analysis, noting that "in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" *Cruzan*, 497 U.S. at 277-78 (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)).

As in *Cruzan*, this Court "must begin with a careful description of the asserted right." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The issue here is not, as a general matter, whether "there is a liberty interest protected by the Fourteenth Amendment in committing suicide that includes assistance in doing so," Wash. Br. at 21, but a much narrower question -- whether the assisted suicide statute is unconstitutional as applied to terminally ill patients who seek the aid of a physician in obtaining medication to hasten their own death.[4]

In *Cruzan*, this Court recognized that the Due Process Clause of the Fourteenth Amendment protects an individual's decision to hasten his or her death by withdrawing life-sustaining treatment. Surveying both the common law[5] and this Court's decisions defining the

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[4] Fundamental principles of judicial restraint counsel against resolving the constitutionality of other applications of these statutes, especially in the absence of full briefing on these issues. *See Ashwander v. TVA*, 297 U.S. 288, 346 (1936) (Brandeis, J., concurring) (noting that the "Court will not 'anticipate a question of constitutional law in advance of the necessity of deciding it'") (quoting *Liverpool, New York & Philadelphia Steamship Co. v. Commissioners of Emigration*, 113 U.S. 33, 39 (1885)).

[5] Although this Court in *Cruzan* began its opinion with a lengthy discussion of the common law's protection of bodily integrity, this Court's opinion did not merely constitutionalize the common law right.

(continued...)

substantive reach of the Due Process Clause, Chief Justice Rehnquist's opinion for the Court found that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." *Id.* at 278. Furthermore, the Court explained that the "logic" of its cases defining the scope of liberty under the Due Process Clause "would embrace . . . a liberty interest" to decline "artificially delivered food and water essential to life." *Id.* at 279; *id.* at 281 ("the Due Process Clause protects . . . an interest in refusing life-sustaining treatment").

Because Missouri did not seek to deprive her of the ability to end her life by withdrawing life-sustaining treatment, but merely required that Ms. Cruzan -- like all other incompetent patients -- offer clear and convincing evidence that she wanted to withdraw life support, the lead opinion spent little time analyzing the contours of Nancy Cruzan's liberty interest. Nevertheless, the separate opinions of the Justices extensively considered whether Nancy Cruzan had a protected liberty interest. These opinions guide the analysis here.

Justice O'Connor joined with the four dissenting Justices in finding that the Constitution protects an individual's decision to hasten death by withdrawing life-sustaining treatment.[6] Noting that "our notions of liberty

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[5] (...continued)
Instead, the Court sharply distinguished the common law precedents, noting that state courts have a number of sources of law "not available to us." *Id.* at 277. After examining its own precedents, the Court then determined that the Constitution protects an individual's decision to decline life-sustaining treatment. *Id.* at 278-79.

[6] Justice Scalia also filed a concurring opinion. Disagreeing with the majority opinion as well as the separate opinions of Justice O'Connor

(continued...)

are inextricably intertwined with our idea of physical freedom and self-determination," Justice O'Connor found that the State's imposition of life-sustaining medical treatment on an unwilling competent adult impinged on an individual's constitutionally protected liberty interests. *Id.* at 287 (O'Connor, J., concurring). As she explained, "[a] seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining treatment or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion." *Id.* at 288 (O'Connor, J., concurring).

As Justice O'Connor noted, forcing an individual to remain on life-sustaining treatment is a significant deprivation of liberty for two reasons. First, the Constitution protects bodily integrity. *Id.* at 287 (O'Connor, J., concurring) ("the Court has deemed state incursions into the body repugnant to the interests protected by the Due Process Clause"). Second, mandating medical treatment deprives a patient of her decisional autonomy concerning her body. *Id.* at 289 (O'Connor, J., concurring) ("Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment.").

Moreover, this deprivation of liberty is especially severe where an individual's decision to refuse treatment will hasten his or her death. These private and intimate

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[6] (...continued)
and the four dissenting Justices, he argued that the refusal of life-sustaining treatment was a form of suicide, and, like all forms of suicide, received no constitutional protection. *Id.* at 292-301 (Scalia, J., concurring).

decisions lie at the core of the liberty protected by the Due Process Clause. As Justice O'Connor explained, "the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.*

Like Justice O'Connor, Justice Brennan and Justice Stevens, in dissent, emphasized that forcing an individual in a persistent vegetative state to use life-sustaining treatment intrudes on his or her bodily integrity and strikes at the core of the personal autonomy over intimate and private matters protected by the Due Process Clause. As Justice Brennan explained, the Constitution protects an individual's decision to hasten his or her death by refusing life-sustaining treatment because "[d]ying is personal. And it is profound. For many the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence." *Id.* at 310-11 (Brennan, J., dissenting).

Justice Stevens sounded this same theme in his separate dissent:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental," and indeed are essential incidents of the unalienable rights to life and liberty endowed us by our Creator.
>
> The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from

> faith, and that is reason alone to protect the freedom to conform choices about death to individual conscience.

Id. at 343 (Stevens, J., dissenting) (citations omitted) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

Consistent with *Cruzan*, other decisions of this Court recognize that the Constitution provides heightened protection to dying persons. For example, in *Roe*, even the dissenters recognized that a state could not prohibit abortions in all cases; at the very least, a state could not prohibit a woman from obtaining an abortion where continued pregnancy would endanger her life. *See Roe*, 410 U.S. at 173 (Rehnquist, J., dissenting). Thus, then-Justice Rehnquist recognized that a dying woman is entitled to stronger constitutional protection than all other women. The choice, however, remains the woman's to make. The State cannot force her to obtain an abortion even where continued pregnancy will lead to her death.

In an effort to distinguish the protections *Cruzan* affords to individuals to hasten their death, the State of Washington argues that its absolute prohibition does not implicate a protected liberty interest because it does not compel anyone to use life-sustaining treatment, but rather, prohibits terminally ill persons from choosing to take medication to hasten death. *See* Wash. Br. at 28-30.

But it is well-established that the Constitution's protections of the body are not limited to halting governmental intrusions into the body. The Constitution also guarantees decisional autonomy concerning one's body, affording individuals both the right to seek and the right to decline medical treatment. Indeed, this Court's cases

concerning the Constitution's protection of bodily integrity have long recognized a close connection between bodily integrity and personal autonomy. The Constitution protects against governmental intrusion into one's body in order to protect the individual's freedom to make decisions concerning her body. As Justice O'Connor explained in *Cruzan*, this Court has deemed "state incursions into the body repugnant to the interests protected by the Due Process Clause," precisely because "our notions of liberty are inextricably intertwined with our idea of physical freedom and self-determination." *Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring).

Individual self-determination over one's body is not limited to the freedom to reject medical treatment. Bodily integrity and autonomy, if it is to mean anything, must include a patient's freedom to choose a course of medical treatment. After all, "[n]o right is held more sacred . . . than the right of every individual to the possession and control of his person, free from all restraint and interference from others . . . ." *Botsford*, 141 U.S. at 251.

Similarly, by prohibiting terminally ill patients from making the deeply personal decision to take medication to hasten death, the Washington statute at issue here deprives these patients of the ability to exercise control over the manner of their death, their bodies, and "the course of [their] own medical treatment," *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring), often forcing them to endure anguish and pain until they die. Indeed, for terminally ill patients, the prospect of death defines their existence and circumscribes the exercise of their life choices. Because much of their lives have become focused on preparation for death, the decision about whether to hasten death is often one of the few defining decisions that terminally ill persons may make concerning their lives.

Furthermore, Washington's absolute prohibition on medical assistance to hasten death leaves terminally ill patients with only two choices: to remain on treatment regimes, which often require them to endure intense anguish and pain, and prolong their life, or to refuse treatment, thereby causing them even more severe pain. To many this dilemma leaves terminally ill patients feeling "captive of the machinery" required for their treatment, "burdening [their] . . . liberty interests as much as any direct state coercion." *Id.* at 288 (O'Connor, J., concurring); *see also Washington v. Harper*, 494 U.S. 210, 229 (1990) ("The forcible injection of medication into a nonconsenting person's body represents a substantial interference with that person's liberty."); *Winston*, 470 U.S. at 766 (finding that "the intrusion on [suspect's] privacy interests entailed by the [surgical operation to remove evidence from his body] can only be characterized as severe"); *Rochin*, 342 U.S. at 174 (finding that forcible stomach pumping was "so brutal and so offensive to human dignity" as to violate due process). By forcing plaintiffs to undergo these state-mandated harms when their physicians could provide medication to relieve their pain, once and for all, the statutes here deprive them of a substantial liberty interest.

Washington also argues that the Constitution affords no protection to the decision to seek medication to hasten death because of the long history of state statutes banning assisted suicide. Wash. Br. at 21-25. But this Court has long rejected the view that the Due Process Clause protects only those practices historically permitted by the states. The right to use contraceptives, the right to choose abortion, the right to marry a person of another race, and the right to be free of state-mandated segregated schooling are among the rights protected by the Due Process Clause despite a long history of statutes denying these rights. *See Roe*; *Loving v. Virginia*, 388 U.S. 1 (1967); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Bolling v. Sharpe*, 347 U.S. 497 (1954).

As this Court explained nearly thirty years ago, "we have never been confined to historic notions of equality, any more than we have restricted due process to a fixed catalogue of what was at a given time deemed to be the limits of fundamental rights." *Harper v. Virginia State Bd. of Elections*, 383 U.S. 663, 669 (1966). "The very purpose of a Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts." *West Virginia State Bd. Of Educ. v. Barnette*, 319 U.S. 624, 638 (1943). The Constitution's protections "may not be submitted to a vote; they depend on the outcome of no elections." *Id.* at 638.

Moreover, as this Court has often recognized, relying exclusively on what the states have legislated in determining the scope of the Constitution's protections would imperil numerous constitutional freedoms recognized by this Court's decisions. *See Board of County Comm'rs, Wabaunsee County, Kansas v. Umbehr*, 116 S. Ct. 2342, 2350 (1996) (refusing to carve out "a special exception to our unconstitutional conditions precedents" based on "'long and unbroken tradition'" of patronage contracting); *Lee v. Weisman*, 505 U.S. 577, 626 (1992) (Souter, J., concurring) (noting that if early American history were "determinative . . . evidence of constitutional meaning, we would have to gut our current First Amendment doctrine to make room for political censorship"). As these cases demonstrate, there are sound reasons for this refusal to place reliance on historical practice in determining the scope of the liberty protected by the Due Process Clause. "A prime part of the history of our Constitution . . . is the

story of the extension of constitutional rights and protections to people once ignored and excluded." *Virginia*, 116 S. Ct. at 2287.[7]

II. THE STATE INTERESTS DO NOT JUSTIFY WASHINGTON'S ABSOLUTE PROHIBITIONS UNDER *CRUZAN*'S BALANCING ANALYSIS.

In *Cruzan*, this Court applied a balancing test to determine whether Missouri could require a showing of clear and convincing evidence before permitting an incompetent patient to terminate life-sustaining treatment. As Chief Justice Rehnquist announced in *Cruzan*, "determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'" *Cruzan*, 497 U.S. at 279 (footnote omitted) (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Unlike the undue burden standard used in *Casey* to evaluate restrictions on pre-viability abortions and the more traditional strict scrutiny standard, *Cruzan*'s balancing test is a more flexible standard. A reviewing court must weigh both the nature and character of the liberty deprivation and

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[7] Furthermore, the relationship between terminally ill persons and the state has changed significantly since the initial passage of the assisted suicide statutes in the 19th century. Because of advances in medicine, terminally ill persons can now survive, and in some circumstances endure pain, far longer than in the past, raising bio-ethical issues uncommon in earlier times. *Cf. Brown v. Board of Educ.*, 347 U.S. 483, 492-493 (1954) ("[W]e cannot turn the clock back to 1868 . . . . We must consider public education in light of its full development and its present place in American life throughout the Nation.").

the asserted state interests in determining the validity of the state's regulation. *See Cruzan*, 497 U.S. at 279-287. The rigor of the Court's review of the state interests depends on the burden imposed by the statute. Where the individual's liberty interest is substantial, the state must come forward with a correspondingly substantial justification, requiring the court to consider the possibility of less intrusive alternatives. *See Riggins*, 504 U.S. at 134-35 (because forced injection of antipsychotic drugs is a substantial interference with a convicted prisoner's liberty interests, a state must show "overriding justification" to support forcible medication, including consideration of less intrusive alternatives).

There can be no question that the statutory prohibitions here deprive terminally ill persons of a substantial liberty interest. These statutes bar, without exception, all terminally ill persons from seeking medication to hasten death, preventing them from making the deeply personal decision to hasten death, and depriving them of the power to exercise control over their bodies in an effort to avoid the intense and brutal pain caused by their illness. *See supra* § I.B.

In its brief to this Court, Washington offers two rationales for its total prohibition on this substantial liberty interest: the protection of human life and the protection of vulnerable patients from mistake and abuse. *See* Wash. Br. at 33-38. Neither of these important interests, however, supports the complete prohibition at issue here. Moreover, these interests do not explain or justify the lines drawn by the Washington legislature.

In *Cruzan*, this Court considered whether a state could require a showing, by clear and convincing evidence, that an incompetent patient desired to withdraw life-sustaining

treatment before terminating such treatment. In considering that regulatory measure, the Court found that the state's interest in protecting human life outweighed Nancy Cruzan's constitutionally protected liberty interest in terminating her life by ending life-sustaining treatment without meeting the requisite burden of proof. *Cruzan*, 497 U.S. at 280-87. Here, however, the question is not whether the state can require proof that the patient, as opposed to some third party, desires to hasten death, but whether the state can override the clearly expressed wishes of a terminally ill patient who is suffering unendurable pain in the last days of life. The answer must be no.

This Court's precedents concerning "personal autonomy and bodily integrity" have long recognized that a "State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." *Casey*, 505 U.S. at 857 (citing, *inter alia, Cruzan*). This must certainly be the case where, as here, the state seeks to further this interest by preventing terminally ill patients from ending their life in dignity, in their own way and on their own terms. Ever since the New Jersey Supreme Court's landmark decision in *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976), courts have refused to force terminally ill patients "to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive and sapient life." *Id.* at 663. Instead, as in *Quinlan*, the state's interest in preserving life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." *Id.* at 664. Where, as here, the life of a terminally ill person is nearing its end and that person is suffering from intense pain, that individual's substantial liberty interest in bodily

integrity surely must "overcome the State interest." *Id.*[8]

Moreover, Washington itself recognizes, in the context of a patient's request to terminate life-sustaining treatment, that the interest in preserving life must give way to the individual's right to control his body and die with dignity. By court decision and statute, Washington law permits a terminally ill patient to hasten death by refusing life-sustaining treatment or by directing physicians to remove such treatment. *See Compassion in Dying*, 79 F.3d at 817-18 (reviewing legislative enactments and caselaw). These statutes and court decisions, which recognize that the state's interest in the preservation of life cannot justify overriding the wishes of a terminally ill person who seeks to hasten his

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[8] Despite the differences in the right at stake and the state interests, this Court has struck a similar balance in its decisions from *Roe* to *Casey*, finding that the state's interest in the potential life of a viable fetus cannot outweigh a woman's decisions concerning her life or health. *See supra* at 12-13. Rather than permitting the state to override a woman's decisional autonomy in these matters, the Constitution makes the woman the final arbiter of her fate, free to choose life or death consistent with her own moral code and religious beliefs. *Cf. Baby Boy Doe*, 632 N.E.2d at 332 ("[A] woman's right to refuse invasive treatment, derived from her rights to privacy, bodily integrity, and religious liberty, is not diminished during pregnancy. The woman retains the same right to refuse invasive treatment, even of lifesaving or other beneficial nature, that she can exercise when she is not pregnant."). Ceding to the state the central authority to weigh these deeply personal matters not only violates the principles of self-determination and autonomy that generally govern health care decision-making, but strikes at the heart of the freedom of conscience and religious belief. If the state's interest in life justified overriding the woman's choice, a state could force a terminally ill pregnant woman to obtain an abortion to save her life, even when she chooses for religious reasons to sacrifice herself to the developing life within her. This recognition of bodily integrity and autonomy, even where the state interest is strong, is instructive where, as here, terminally ill patients are making equally momentous medical decisions concerning their lives.

death by terminating life-sustaining treatment, powerfully undermine Washington's claim that a total prohibition is necessary to further its legitimate interest in preserving life. *See City of Ladue v. Gilleo*, 114 S. Ct. 2038, 2044 (1994) (noting that exemptions from ban on homeowners displaying signs on their property "diminish[es] the credibility for [speech prohibition] in the first place" because they show that the city has "determined that some of the[] [signs] are too vital to be banned"). State regulatory efforts, like those upheld by this Court in *Cruzan*, can strike the proper balance between the individual's freedom to control his or her body and die in a dignified manner and the state interest in preserving life. Here too, Washington's statutes and cases recognize that, for terminally ill patients, decisions concerning whether to die with dignity are "too vital to be banned." *Gilleo*, 114 S. Ct. at 2044.

In an effort to distinguish this body of law, Washington and their *amici* argue that there are differences between terminating life-sustaining treatment and prescribing medication: in one instance, the physician lets the patient die; in the other, the medication causes the patient's death. Wash. Br. at 37-38; U.S Br. at 28 (No. 96-110). This is a distinction, but not a relevant one for constitutional line-drawing. It does not explain why the state's interest in preserving life must give way to the right of a terminally ill patient to hasten death by terminating or refusing life-sustaining treatment, but not the right of a terminally ill person to seek medication to hasten death. In both instances, the patient's decision inevitably results in death. If the state's interest in life does not support a complete ban on terminating life-sustaining treatment, it is difficult to understand why that same interest supports the ban here simply because death occurs in a different manner.

A similar analysis applies to the state interest in avoiding mistake and abuse. There can be no doubt that this is a legitimate interest and would support state regulation concerning the procedures required before a physician could prescribe medication to hasten death. But it cannot support the total prohibition at issue here any more than can the state's interest in preserving life.

Termination of life-sustaining treatment raises exactly the same problems concerning mistake and abuse as the prescription of medication to hasten death. In both cases, doctors may abuse their authority and pressure terminally ill persons to hasten their deaths. Washington has not explained why the pressures exerted by physicians in this context -- both subtle and otherwise -- are any different when a physician withdraws a patient's life-sustaining treatment. In the face of this silence, the untested assumption that procedural safeguards would be unworkable is wholly unreasonable and cannot justify the absolute prohibition here.

The United States, in an effort to distinguish the two practices, argues that a patient's choice to hasten death often reflects inadequate treatment for the patient's pain, not a true desire to hasten death. The total ban, they argue, should be upheld because of a "very significant risk that persons with treatable depression and pain will be allowed to commit suicide." U.S. Br. at 23 (No. 96-110). Even if this is an "overriding interest," *id.*, far less intrusive measures could allay this concern without the need for the flat prohibition imposed by the state. Before permitting physicians to prescribe medication to hasten death, states have broad discretion to enact measures to ensure that a patient's decision is truly voluntary, and not the result of inadequate pain management. The State has failed to explain why these less intrusive measures would not

adequately serve this interest. *Cf. Riggins*, 504 U.S. at 135-36. Indeed, the protocols used by Compassion in Dying illustrate some of the procedural safeguards available to ensure voluntariness. *See Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1458 (W.D. Wash. 1994).[9]

In view of the plaintiffs' strong liberty interest and the state's inability to convincingly explain why a prohibition is necessary here, but not in the context of the termination of life-sustaining treatment, these statutes must be declared unconstitutional as applied to plaintiffs.

CONCLUSION

For all the foregoing reasons, *amicus* respectfully urge this Court to affirm the decision of the court of appeals.

Dated: December 10, 1996

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[9] The same is true of the argument that physicians will misdiagnose some patients as terminally ill. A prohibition is a patently overbroad and unreasonable approach to this concern. Regulatory measures, such as a statutory definition of terminal illness, are more than sufficient to serve this interest.

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No. 96-110

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE,
Attorney General of Washington,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Ninth Circuit

BRIEF AMICI CURIAE OF COUNCIL FOR SECULAR HUMANISM AND INTERNATIONAL ACADEMY OF HUMANISM IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Whether a state may compel a terminally ill, competent person to live in irremediably painful and degrading conditions by absolutely prohibiting her from receiving the assistance she requires to end her life.

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BRIEF AMICI CURIAE OF COUNCIL FOR SECULAR HUMANISM AND INTERNATIONAL ACADEMY OF HUMANISM IN SUPPORT OF RESPONDENTS

INTEREST OF THE AMICI CURIAE

The Council for Secular Humanism is a non-profit educational organization, headquartered in Buffalo, New York, dedicated to fostering the growth of the traditions of democracy, respect for human rights and the principles of free inquiry. The Council is responsible for publishing the quarterly, Free Inquiry. The Council has always had a keen interest in promoting and protecting individual autonomy and has published numerous articles and sponsored symposia discussing the morality and legality of assisted suicide and euthanasia. *E.g., The Case For*

Active Voluntary Euthanasia, 9 Free Inquiry 3-21 (Winter 1988).

The International Academy of Humanism is an affiliate of the Council established to draw on the resources of various distinguished writers, academics, politicians and scientists (including Nobel laureates) in disseminating humanistic ideals and beliefs. The Secretariat of the International Academy of Humanism consists of Vern Bullough, professor of history, California State University; Antony Flew, professor emeritus of philosophy, Reading University; Paul Kurtz, professor emeritus of philosophy, SUNY at Buffalo; Gerald Larue, professor emeritus of archaeology and biblical studies, University of Southern California at Los Angeles; and Jean-Claude Pecker, professor of astrophysics, Collège de France, Académie des Sciences. (A complete listing of the members of the Academy may be found at 16 Free Inquiry 66 (Fall 1996).) Although the members of the International Academy of Humanism have divergent views about the circumstances under which assisted dying is morally justifiable and should be legally permissible, they believe that an absolute ban on assisted suicide violates a liberty interest of the terminally ill.

Through their counsel, the parties have consented to the appearance of these *amici*.

SUMMARY OF ARGUMENT

"Our Constitution is designed to maximize individual freedom within a framework of ordered liberty." *Kolender v. Lawson*, 461 U.S. 352, 357 (1983). Compelling a competent person to remain alive under conditions she finds irremediably painful and degrading is starkly inconsistent with the respect for personal autonomy that is an intrinsic part of our national heritage. In forcing someone to remain alive against her will, the State appropriates her life. The only conceivable comparison to the horror

of a compelled life would be compelling a person to marry, and spend all her waking hours with, someone she finds utterly loathsome.

An absolute ban on assisted suicide has the effect of compelling the terminally ill to remain alive. Unassisted suicide is an option only for the robust and healthy. The terminally ill are, in most cases, too debilitated, confined and dependent on others to have the ability to use, and obtain access to, violent means of causing death, and, of course, the State maintains control of the dispensation of lethal medications. As applied to the terminally ill, a blanket prohibition of assisted suicide is unduly burdensome as it deprives them of the freedom of abandoning an existence they find unbearable.

Contrary to the suggestion of petitioners and their *amici*, respondents are not asking this Court to authorize unbridled liberty. Conduct harmful to others is always subject to reasonable regulation. However, exercise of a fundamental liberty interest cannot be absolutely prohibited based on vague speculation about indirect harm to others. Instead, this Court's rulings require a showing of the gravest imminent danger to the public safety to justify a substantial deprivation of liberty. *Kent v. Dulles*, 357 U.S. 116, 128-29 (1958). The State's legitimate interest in preventing those who reject assisted suicide from being pressured or manipulated into requesting assistance in dying can be served by stringent regulation short of an absolute ban.

An instructive analogy can be made to the freedom to bear and beget children. There is incontrovertible evidence that child abuse, up to and including the murder of children, is linked to a family's income. A licensing scheme that would prohibit persons from having children until they reached and maintained a certain income level would save thousands of children annually. However, no one seriously entertains such a proposition; we place too

high a value on choices central to personal dignity and autonomy.

If this Court is to be faithful to our constitutional heritage, it must find that the State cannot compel a terminally ill person to live when respect for her autonomy presents no imminent danger of harm to others.

ARGUMENT

I. A STATE'S ABSOLUTE BAN ON ASSISTED SUICIDE VIOLATES THE FUNDAMENTAL LIBERTY INTEREST IN NOT BEING COMPELLED TO LIVE IN IRREMEDIABLY PAINFUL AND DEGRADING CONDITIONS

The issue before the Court is whether an individual competent to make decisions on fundamental matters that give shape, direction and personal significance to her life may be compelled to remain alive under conditions she finds irremediably painful and degrading.[1] Consistent with this Court's recognition that the Due Process Clause of the Fourteenth Amendment establishes "a realm of personal liberty which the government may not enter," *Planned Parenthood v. Casey*, 505 U.S. 833, 847 (1992), this Court should rule that a blanket prohibition on assisted suicide cannot withstand scrutiny. With respect to the terminally ill, that is, individuals who in most circumstances will be "too weak, too debilitated, or too dependent on others"[2] to bring about their own unassisted deaths effectively, an absolute ban on assisted suicide results in the state's appropriation of their lives: Their autonomy and liberty have been entirely eliminated.

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[1] When using third-person singular pronouns, this brief will use both genders. This is a stylistic choice that carries no further significance.

[2] Erich H. Loewy, *Healing and Killing, Harming and Not Harming: Physician Participation in Euthanasia and Capital Punishment*, 3 J. of Clinical Ethics 29, 30 (1992).

A. The Nature of the Liberty Interest at Stake

A critical consideration at the outset of any analysis of the liberty interest of the terminally ill in assisted suicide is an understanding of the extent to which self-determination is implicated. The United States has candidly acknowledged that there is a constitutionally protected liberty interest at issue in these cases, but it characterizes this interest as the interest a person has in "avoiding severe pain or suffering." Brief of the United States as Amicus Curiae Supporting Petitioners (in *Washington v. Glucksberg*) at 16 (hereinafter "United States Brief"). This description of the liberty interest is misleading because it is far too circumscribed.[3]

In articulating the precise interest at issue, one must bear in mind the difference between occurrent or limited interferences with one's liberty and comprehensive interferences with one's liberty. Joseph Raz, *The Morality of Freedom* 370-74 (1986). *See also* David Archard, *For*

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[3] At least the United States recognizes that the terminally ill do have a liberty interest that could be pursued through assisted suicide. The State of Washington, on the other hand, along with several *amici* supporting petitioners, suggests there is no liberty interest at stake as "[d]eath is in fact the antithesis of liberty." Brief for Petitioners (in *Washington v. Glucksberg*) at 28. No one would dispute that the dead do not act freely: They do not act at all. However, the focus must be on the right of a person to be free *from* conditions that are oppressive. Unfortunately, some persons find themselves in situations that are literally unbearable and from which the only escape is death. That death may be preferable to a humiliating, degrading, confined existence is a belief that has been rationally held by countless human beings in all ages of human existence. Indeed, many who helped found this country shared this sentiment. The implication of the argument advanced by the State of Washington and several of its *amici* is that Patrick Henry was an incoherent, babbling idiot when he uttered the phrase "give me liberty or give me death." J. Axelrad, *Patrick Henry: The Voice of Freedom* 110-111 (1947). Surely, this Court's constitutional jurisprudence cannot be predicated on such a ludicrous proposition.

Our Own Good, 72 Australasian J. of Phil. 283 (1994). A limited interference with liberty restrains someone from undertaking a particular act or series of acts, such as selling or purchasing corrective lenses without a prescription, *see, e.g., Williamson v. Lee Optical,* 348 U.S. 483 (1955), that has few ramifications for one's central projects in life. A comprehensive interference with liberty affects a wide range of a person's choices. Comprehensive interferences with liberty are, of course, in need of greater justification. Thus, while a state may readily require someone who chooses to pursue a certain specific safety-related occupation to alter his personal appearance slightly, *Kelley v. Johnson,* 425 U.S. 238, 248-49 (1976), it cannot, without a compelling justification, foreclose a whole range of occupations to persons apparently competent to discharge their professional duties in such occupations. *Hampton v. Mow Sun Wong,* 426 U.S. 88, 102-03 (1976). This intuitive distinction, of course, underlies this Court's jurisprudence with respect to fundamental liberty interests. Fundamental liberty interests are those matters involving "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey,* 505 U.S. at 851. Such choices include "the decision whether to bear or beget a child," *Eisenstadt v. Baird,* 405 U.S. 438, 453 (1972), and the choice of a spouse. *Loving v. Virginia,* 388 U.S. 1, 12 (1967). Such choices affect the very pattern of one's existence; they are the choices through which a person defines himself.

Some interferences with liberty can be so comprehensive that they usurp all of a person's decisions with the result that that person loses control of his life. There can be no more intimate, self-defining decision for a person than the decision whether to continue living. If the degree to which one's autonomy has been violated is a function of the extent to which a person is forced to reorder his life, to redefine himself, then it is no exaggeration to state that

a person forced to remain alive against his will has been totally deprived of his autonomy. When a competent person has reached the conclusion that his life is, on balance, too painful, too degrading, too restricted to be worth living, *for him* there are no activities worth pursuing given the conditions in which he finds himself.[4] To force him to continue living is to condemn him to an existence that has, for him, lost any value. If a person in such circumstances longs to die, but is prevented from doing so, he can no longer make any autonomous choices because his entire existence is compelled. As the legal philosopher Joseph Raz has observed, "[a] person whose every decision is extracted from him by coercion is not an autonomous person." *The Morality of Freedom, supra,* at 373.

The liberty interest at stake in this case is not merely the interest in being free from pain. It is the interest in not being forced to pursue a pain-filled or distressing and restricted life devoid of any subjective meaning and personally abhorrent.[5] A useful analogy can be made to

[4] We emphasize that this is a personal decision for each individual. Some persons may find value in a life in which they are bedridden and racked with pain, perhaps because such suffering has a religious significance for them. *See, e.g.,* John Paul II, *The Gospel of Life* 26-27 (1995). That is why some of petitioners' *amici* are in error when they suggest that recognition that the terminally ill have a liberty interest in assisted suicide "would reflect a judgment by the state that some people are better off dead than alive." Brief *Amici Curiae* of the United States Catholic Conference at 16. It is the individual whose life it is that decides whether his life is worth pursuing. Recognition that a person has a liberty interest in making this choice does not result in the State's endorsement of any particular person's choice any more than the State's allowing persons the freedom to bear or beget a child or to marry results in the State's endorsement of any particular person's choice. Forbearance from interference with another's actions cannot be equated with approval of that person's actions. In "defin[ing] the liberty of all," this Court does not "mandate [its] own moral code." *Casey,* 505 U.S. at 850.

[5] It is important to emphasize that it is not merely pain that motivates many of the terminally ill to elect death, but also "suffer-

"[t]he freedom to marry," described by this Court as "essential to the orderly pursuit of happiness." *Loving*, 388 U.S. at 12. Obviously, the very idea of depriving a competent adult of the opportunity to marry the person of her choice is repugnant. However, being kept alive against one's will involves an even greater violation of autonomy. A compelled life can be appropriately compared only to being forced to marry, and spend all one's waking hours with, a person that one finds utterly loathsome. A person kept alive against her will is similarly yoked to abominable conditions. "Our whole constitutional heritage rebels at the thought of giving government the power to control men's minds." *Stanley v. Georgia*, 394 U.S. 557, 565 (1969). In depriving someone of needed assistance in dying, and thereby forcing that person to live, the government assumes complete control of that person's mind, body and spirit.

B. The Need of the Terminally Ill for Assistance in Dying

In his classic article against the legalization of assisted dying, Yale Kamisar argued, among other points, that the extent to which laws against assisted dying infringed on liberty interests had been overstated. Prohibitions on

ing" in the sense of extreme discomfort, distress and loss of functional capacity. Although "medical science does manage to save many dying patients from the extreme of physical pain . . . it often fails to save them from an artificial twilight existence, with nausea, giddiness and extreme restlessness, as well as the long hours of consciousness of a hopeless condition." Glanville Williams *"Mercy-Killing" Legislation—A Rejoinder*, 43 Minn. L. Rev. 1, 8-9 (1958). In fact, for many, both in ancient and contemporary times, loss of functional capacity and accompanying distress may be more unbearable than physical anguish. Margaret Pabst Battin, *The Least Worst Death* 134 (1994) (discussing requests for assisted dying in the Netherlands); 1 Seneca, *Ad Lucilium Epistulae Morales* 409 (Richard M. Gummere trans., William Heinemann) (1917) (not pain, but the limitations resulting from pain, as removing the reasons for living).

assisted suicide or euthanasia, after all, are directed against the person providing assistance, not the person who receives the assistance. There are no longer any criminal penalties for suicide or attempted suicide, so, superficially, any person's interest in escaping a life he finds unacceptable could be accommodated by a simple policy of noninterference in suicides:

> Finally, taking those who may have such a desire [to die], again I must register a strong note of skepticism that many cannot do the job themselves. . . . [A] *laissez-faire* approach in such matters [may be preferable to] an approach aided and sanctioned by the state.[6]

This contention has some merit if one focuses only on the physically robust. Indeed, offering assistance to those truly capable of doing "the job themselves" improperly circumvents an important psychological barrier to hasty, ill-considered suicides—leaving aside any moral problems that may be raised by the offer of such assistance. Generally speaking, if a healthy, able-bodied person is too ambivalent to kill himself without assistance, suicide is, for him, almost surely the wrong decision.

However, unassisted suicide is only an option for those with access to the proper means and the physical strength to use them. As the State maintains control of the dispensation of lethal medications, a person must have access to firearms, knives, ropes or other violent means of death and possess the ability to use these violent means effectively if he is to kill himself without assistance. In the last stages of a terminal illness "the patient is likely to lack the capacity to commit suicide on his own." Richard A. Posner, *Aging and Old Age* 238 (1995). "Physically frail, confined to wheelchairs or beds, many terminally ill patients do not have the means or ability to kill them-

[6] Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 Minn. L. Rev. 969, 1011 (1958).

selves." *Compassion in Dying v. Washington*, 79 F.3d 790, 832 (9th Cir. 1996). *See also* Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* 114 (1994); Loewy, *Healing and Killing, Harming and Not Harming, supra*, at 30. For someone in such a situation, being denied assistance effectively results in that person being kept alive against his will. The principal reason why the terminally ill have such a strong liberty interest in assisted suicide is because they need assistance to die, whereas the overwhelming majority of those who are not terminally ill require no such assistance.[7]

Accordingly, a regulatory scheme that might seem appropriate in the abstract—allowing persons to commit unassisted suicide, but prohibiting assisted suicide—may be unduly burdensome and restrictive when applied to a class of individuals. This Court has not hesitated to strike down legislation that effectively prevents some from pursuing a fundamental liberty interest even though there is no direct restriction on the exercise of that liberty. Thus, a statute requiring a person to fulfill certain financial obligations prior to marrying is unconstitutional if the result is that some persons "are absolutely prevented from getting married." *Zablocki v. Redhail*, 434 U.S. 374, 386 (1978). "The proper focus of constitutional inquiry is the group for

[7] In emphasizing that the need for assistance is the principal factor supporting the strength of the interest of the terminally ill in assisted suicide, we are not implying there are no other factors. The fact that for the terminally ill the choice is really between a prolonged, agonizing death and a peaceful death distinguishes their situation from those who are not terminally ill. *See In Re Quinlan*, 355 A.2d 647, 664 (N.J.), *cert. denied*, 429 U.S. 922 (1976) ("[T]he State's interest . . . weakens and the individual's right to privacy grows as the . . . prognosis dims."). However, the implications of the fact that for the terminally ill assisted dying is more appropriately characterized as a means of hastening death rather than suicide in the traditional sense is a subject explored in depth by the respondents and other *amici* and there is no need for further analysis here.

whom the law is a restriction, not the group for whom the law is irrelevant." *Casey*, 505 U.S. at 894. As applied to the terminally ill, a blanket prohibition on assisted suicide is unduly burdensome as it deprives them of the freedom of abandoning an existence they find irremediably painful and degrading.

Of course, not everyone who has just received a diagnosis that he is terminally ill will lack the vigor necessary to secure a knife and slash his wrists. However, every responsible proposal for regulating—as opposed to banning—assisted suicide envisions a waiting period of at least a few weeks during which the competency of the person requesting assistance in dying can be assessed and alternatives to suicide explored. *E.g.*, Franklin G. Miller, et al., *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994). During this time, the patient's strength and mobility will likely be diminishing substantially.

Moreover, a justification for continuing the ban on assisted suicide predicated on the possibility that most of the terminally ill will be able to "do the job themselves" if they only act quickly enough is inconsistent with the State's interest in preserving life. Such a ban on assisted suicide will result (and has resulted) in many precipitous or unnecessary suicides. Persons will kill themselves months before they would die if legalized assisted suicide were available. Others will kill themselves who, had they been able to wait to determine whether they wanted assistance in dying, would not have found their lives unbearable. In other words, assuming we desire a regulatory scheme that encourages persons to live as long as they find their lives worthwhile, a policy of permitting assisted suicide for the terminally ill is much more likely to accomplish this end than a continuation of the ban on assisted suicide. As Judge Posner has perceptively stated:

> If the only choice is suicide now and suffering later, individuals will frequently choose suicide now. If the

> choice is suicide now or suicide at no greater cost later, they will choose suicide later because there is always a chance that they are mistaken in believing that continued life will impose unbearable suffering or incapacity on them. . . . The possibility of physician-assisted suicide enables them to wait until they have more information before deciding whether to live or die.

Aging and Old Age, *supra*, at 247-48.[8]

In conclusion, with respect to the terminally ill, a ban on assisted suicide impermissibly intrudes on a fundamental liberty interest. When a state's ban on assisted suicide compels a person to lose all control of her life and to endure conditions she fiinds wholly unacceptable and intolerable, the State has unconstitutionally appropriated that person's life by "insist[ing] . . . upon its own vision of [her] role." *Casey*, 505 U.S. at 852.

II. NO COMPETING STATE INTEREST OUTWEIGHS THE FUNDAMENTAL LIBERTY INTEREST IN NOT BEING COMPELLED TO LIVE

Some who are willing to concede that there is a liberty interest that is infringed by a ban on assisted suicide nonetheless contend that various State interests require a continuation of the ban, in particular the State interest in "protecting the lives of those who do not really wish to die, but who request lethal drugs from their doctors because of real or perceived pressure from others to choose death." United States Brief at 26. Distilled to its essential core, this argument is that the State must "sacrifice the autonomy and dignity of some citizens for the safety and support of others." Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey and the Right to Die*, 44 Am. U. L. Rev. 803, 807 (1995).

[8] Judge Posner, of course, wrote this passage in the context of a scholarly work, not in his capacity as a member of the federal judiciary. We should also note, in fairness to Judge Posner, that as a matter of prudential politics he has indicated he would prefer legalization of assisted suicide on a state-by-state basis, given that, in his view, "the United States is a morally heterogeneous country." *Id.* at 260. Recognition of the insightfulness of Judge Posner's analysis of the beneficial effects of legalized assisted suicide does not require acceptance of his political views.

However, once one acknowledges the strength of the liberty interest at stake, a continuation of the absolute ban on assisted suicide requires a compelling justification unlikely to find its source in speculation and *a priori* reasoning about the alleged dangers arising from assisted suicide. "Since we start with an exercise . . . of an activity included in constitutional protection," only "on a showing of 'the gravest imminent danger to the public safety' " can this activity be prohibited. *Kent v. Dulles*, 357 U.S. 116, 128-29 (1958) (quoting *Korematsu v. United States*, 323 U.S. 214, 218 (1944)). Petitioners cannot meet this heavy burden, especially in light of the confirmed but tolerated dangers that arise from the exercise of comparable liberty interests (to be discussed below). "Our Constitution is designed to maximize individual freedom within a framework of ordered liberty." *Kolender v. Lawson*, 461 U.S. 352, 357 (1983). Our Constitution does not contemplate the State's appropriation of the freedom of some of its citizens to serve a nebulous utilitarian goal.

A. Regulation, Not an Absolute Ban, Is the Constitutionally Proper Way to Further the State's Interest in Protecting the Terminally Ill from Undue Influence

"The consequentialist arguments for prohibition [of assisted suicide] for the most part do not rest on issues about the welfare of the patient before the court. Rather, they rely on the risks of abuse and mistake in other cases, and the importance of providing support for life-preserving choices elsewhere." *Does Pro-Choice Mean Pro-Kevorkian?*, *supra*, at 842. The contention is that the State has an interest in protecting those terminally ill who do want

to continue living, but who may be pressured or manipulated into requesting assisted death once it is legalized. Although recognition of a right to assisted suicide will respect the autonomy of many who do not want to be compelled to live in painful, degrading circumstances, it may indirectly result in serious harm to a few, vulnerable persons.

As the court below recognized, "[t]he risk of undue influence is real." *Compassion in Dying*, 79 F.3d at 826. While the risks of abuse are often greatly exaggerated, it would be entirely unrealistic to claim that following legalization of assisted suicide there will be no instances of manipulation or coercion. However, two important considerations indicate that this risk is not sufficient to justify an absolute ban on assisted suicide.

To begin, one must bear in mind that the terminally ill are already susceptible to undue influence when they are presented with the choice of withdrawing or withholding life-sustaining treatment. Furthermore, there are few safeguards in place for undue influence in this context. By contrast, no responsible proponent of legalized assisted suicide maintains that the practice should not be subject to stringent regulation to ensure that the request for assistance in dying is the voluntary choice of a competent person. Thus, with respect to protection of the vulnerable, the primary difference after recognition of a constitutional right to assisted suicide will be that whereas now there are only minimal safeguards against undue influence in life-ending situations, post-recognition there will be reasonably effective safeguards (such as the requirements of express, repeated requests, a waiting period, consultation with an expert in palliative care, etc.) in at least some life-ending situations. As the court below discerned, "[g]iven the possibility of undue influence that already exists, the recognition of a right to physician-assisted suicide would not increase that risk unduly," but "[i]n fact, the direct involvement of an impartial and professional

third party in the decision-making process would most likely provide an important safeguard against such abuse." *Compassion in Dying*, 79 F.3d at 826.

The other relevant consideration is that the Court cannot recognize any important liberty interest without the risk that there will be some who will be unavoidably harmed as an indirect result of the freedom the Constitution allows all. Persons are subject to manipulation and pressure from others at all times, but especially with respect to critical life choices such as which career to pursue, whom to marry, whether to divorce, whether to have a child, whether to abort a fetus, etc. It cannot be a sufficient justification for denying individuals the right to make such choices that the decisions of some are the product of pressure or manipulation. Such an overbearing, all-encompassing paternalism would lead to a denial of autonomy in all important areas of our lives.

To reply that decisions for assisted suicide are different because they result in death does not provide a sufficient reason for denying autonomy in this context. To begin, as two noted moral philosophers have observed in their discussion of the risks of assisted suicide, "we often accept social policies that have some [lethal] risks . . . we allow youths sixteen years of age to drive an automobile on public roads with minimal driver's education, although we know there will be some tragic outcomes." Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 234-35 (4th ed. 1994). Moreover, even if we assume that legalized assisted suicide presents a somewhat greater risk of lethal harm than other freedoms, the proper, measured response would not be to ban assisted suicide entirely, but to insist that there be safeguards in the context of life-ending decisions that do not exist in other areas. Finally, a constitutionally protected fundamental liberty interest cannot be outweighed by the risk that some harm—even lethal harm—will result from the exercise of that protected freedom. An

analysis of one such fundamental liberty interest—the right to bear and beget children—establishes this point.

B. The State Cannot Ban Some Classes of Competent Persons from Bearing and Begetting Children Even Though the Certain Result of Respecting This Liberty Interest Is Thousands of Deaths

Child abuse, up to and including murder of children by their parents, is a very serious problem in this country. In 1993, for example, approximately 1,500 children died as the result of abuse or neglect. U.S. Dep't of Health and Human Serv., *The Third National Incidence Study of Child Abuse and Neglect* 3-12 (1996). Some experts believe the numbers of deaths are significantly underreported and that at least 2,000, and perhaps as many as 5,000, children die annually as the result of abuse and neglect. U.S. Dep't of Health and Human Serv., *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*, 9, 18-19 (1995). Moreover, in addition to fatalities, approximately 18,000 children per year are permanently disabled by abuse or neglect. In fact, "a staggering 9.5 to 28 percent of all disabled persons in the United States may have been made so by child abuse and neglect." *Id.* at 17.

Although persons of all social classes abuse and kill their children, there is a very significant, undeniable correlation between family income and child abuse. Government studies have demonstrated that "higher incidence rates [of abuse] were directly associated with lower income levels, and all differences among the income groups were statistically significant." *Third National Incidence Study* at 5-4. "Children in families with annual incomes lower than $15,000 had the highest rate of abuse" with their rate being "more than two and one-quarter times the rate for children in families with annual incomes of $15,000 to $29,999 . . . and nearly 14 times the rate for children in families with annual incomes of $30,000 or more." *Id.*

One conclusion from this impressive body of empirical evidence is inescapable: if the State were to prohibit persons from having children until they reached and maintained a certain income level, the number of murdered and seriously harmed children would plummet. Thousands of lives would be saved; tens of thousands would be protected against serious injury. Scholars have from time-to-time proposed a licensing requirement for those desiring to have children. *E.g.*, Hugh Lafollette, *Licensing Parents*, 9 Phil. & Pub. Aff. 182 (1980). Nonetheless, such proposals, although obviously well-intentioned and not unworthy of consideration, have almost uniformly been quickly dismissed with incredulity. Nor is there any doubt that were some legislature persuaded that restricting the rights of competent adults to bear and beget children was necessary to prevent "the deaths of other persons whom the State has an unquestionable interest in protecting," *cf.* United States Brief at 22 n.2, this Court would hold such a statute unconstitutional. "If the right of privacy means anything, it is the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child." *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

The price of freedom can be high, but the Constitution requires society to accept this price to protect our fundamental liberty interests. Moreover, it is clear in the context of procreation that a state cannot constitutionally prohibit a class of persons from enjoying a protected liberty interest even though the exercise of that freedom is certain to result in the deaths of thousands each year. Much less can a state assume total control over a person's life by compelling her to live because of risks that even opponents of assisted suicide admit are "imponderable." *Does Pro-Choice Mean Pro-Kevorkian? supra*, at 846 n. 159.

III. OUR CONSTITUTIONAL HERITAGE REQUIRES RECOGNITION OF A FUNDAMENTAL LIBERTY INTEREST

There is no denying that it would be difficult to find a specific reference to a liberty interest in assisted suicide among those who drafted the Constitution and the Fourteenth Amendment. However, acknowledging this fact does not in any way undermine our argument. "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Casey*, 505 U.S. at 848.

It could hardly be otherwise if the Constitution is not to be a static and lifeless document, but rather a document adaptable to changing social circumstances. Our moral norms and our understanding of the bounds of liberty derive from our shared experience, and, for the most part, our ancestors in the 1780's and in the 1860's simply did not die in the same way we do today: Most individuals today die in hospitals after prolonged illnesses, as opposed to being carried off swiftly by contagious diseases or untreatable conditions. *See Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 339-40 (1990) (Stevens, J., dissenting). Unremarkably, the extent to which there is a perceived liberty interest varies with the need for exercise of that liberty. For most persons a century or two ago, assistance in dying was not necessary for them to avoid being kept alive against their will.

History can, nonetheless, be instructive in this case. In this regard it is ironic that some of petitioners' *amici* invoke practices under the Nazi regime as an argument against recognition of a fundamental liberty interest in this case. Brief *Amicus Curiae* of the Evangelical Lutheran Church in America at 23-24. The practice of involuntary "euthanasia" by the Nazis bears no resemblance to the proposed practice of allowing competent,

terminally ill persons to decide for themselves whether to continue living. The Nazis did not embark on a program of assisted dying only to find their respect for human life and liberty slowly corroding. Beauchamp and Childress, *Principles of Biomedical Ethics* at 232. The killing of the disabled by the Nazis was ancillary to the Nazi goal of promoting their vision of the common good by purifying the German race. Richard Breitman, *The Architect of Genocide: Himmler and the Final Solution* 89 (1991).

What the horrifying example of Nazi Germany does do, however, is remind us that during the last few centuries there have been two prominent, competing views of the relationship between the State and the individual. Under one view—the view embraced by fascism, communism and other authoritarian ideologies—the individual is a pawn of the State and is allowed only such freedom as is determined to be in the best interests of the State. The collective common good always has priority over the rights of the individual. Under the other view—the view which motivated those who founded this country—the State is the servant of the people and has no authority to prohibit critical life choices except to the extent those choices present the "gravest imminent danger to the public safety." *Kent, supra*, 357 U.S. at 128. At bottom, this case is about a choice between these two understandings of the role of the State. Our constitutional heritage mandates that this Court find that the right of an individual to give shape, direction and significance to her life may only be balanced against, and cannot be made slavishly subordinate to, the State's vision of the common good: Our constitutional heritage mandates that this Court find that the State cannot compel a terminally ill person to live when respect for her autonomy presents no imminent danger of harm to others.[9]

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[9] In making this argument we are, of course, in no way suggesting that petitioners or their *amici* are advocates of fascism, communism or other authoritarian ideologies. We are suggesting that

CONCLUSION

For all the foregoing reasons, the judgment of the U.S. Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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their arguments, taken to their logical conclusion, have dangerous implications. The State that can disregard personal autonomy and compel individuals to live to promote the State's vision of the common good can also disregard personal autonomy and compel individuals to die to promote the State's vision of the common good.

Nos. 95-1858
96-110

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1995

DENNIS VACCO, Attorney General
Petitioner

v

TIMOTHY QUILL, M.D. (and others)
Respondents

STATE OF WASHINGTON
Petitioner

v

HAROLD GLUCKSMAN
Respondent

ON CERTIORARI TO THE SECOND AND NINTH CIRCUIT COURTS OF APPEAL

BRIEF OF AMICUS CURIAE WAYNE COUNTY, MICHIGAN, IN SUPPORT OF THE PETITIONERS

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STATEMENT OF THE QUESTION

IS THERE IS A DUE PROCESS RIGHT TO COMMIT SUICIDE, ATTEMPT SUICIDE, OR ASSIST IN A SUICIDE, THOUGH THE CONSTITUTION HAS NOTHING TO SAY ABOUT THE SUBJECT?

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INTEREST OF THE AMICUS

Amicus is the County of Wayne. The Wayne County Prosecutor's Office has litigated the issue presented in the cases before the Court throughout Michigan courts, both trial and appellate, and the Michigan Supreme Court has found that there is no due process constitutional right to "assisted suicide." Further, Michigan has been the site of over 40 assisted suicides, and the Michigan legislature is awaiting the outcome of the instant cases before determining how to proceed with regard to future legislation in this area. The result in these cases is of great interest and importance to the County of Wayne.

WHETHER "ASSISTED SUICIDE" SHOULD BE PERMITTED IS A QUESTION LEFT BY THE CONSTITUTION TO THE POLITICAL BRANCHES OF GOVERNMENT, AND TO EACH STATE TO DECIDE FOR ITSELF.

I. The Framework of Review

The starting point for all analysis of the constitutionality of a statute is that the constitutionality of the law in question "is to be presumed, because the legislature, which was first required to pass upon the question, acting, as they must be deemed to have acted, with integrity, and with a just desire to keep within the restrictions laid by the constitution upon their action, have adjudged that it is so." Thomas Cooley, Constitutinal Limitations, at 183. See also People v Collins, 3 Mich 343, 349, 405 (1854); People v Gansley, 191 Mich 347 (1917) ("courts in a long series of cases have enunciated the principle that the presumption is in favor of the constitutionality of a statute"). This may

seem a commonplace, but, as Justice Cooley observed elsewhere in his treatise regarding another maxim of construction, while it may "seem so obvious a truism that one expects to see it universally accepted without question" nonetheless it "frequently becomes necessary to re-declare this fundamental maxim." Cooley, at 59.

Because of this presumption of constitutionality, and also because resolution of a challenge to the constitutionality of a statute is "one of the most grave and delicate duties which a judicial tribunal can be called upon to perform," Collins, at 347, Cooley, at 182, Justice Cooley wrote that "when courts are called upon to pronounce the invalidity of an act of legislation...they will approach the question with great caution...and never declare a statute void, unless the nullity and invalidity of the act are placed, in their judgment, beyond a reasonable doubt.

A reasonable doubt must be solved in favor of the legislative action, and the act be sustained.....'It is but a decent respect due to the wisdom, the integrity, and the patriotism of the legislative body by which any law is passed, to presume in favor of its validity, until its violation of the constitution is proved beyond all reasonable doubt.'" Cooley, at 182-183, quoting Ogden v Saunders, 12 Wheat 270 (1827). See People v Stambosva, 210 Mich 436, 441 (1920) (the rule is that "every intendment is to be taken in favor of the propriety and validity of legislative action, and that in case of doubt courts should not interfere to thwart the legislative will").

Of course, it is also a truism that a court may not invalidate a statute because the court believes it "unjust and oppressive," or because "it is supposed to violate the natural, social, or political

rights of the citizen, unless it can be shown that such injustice is prohibited or such rights guaranteed by the constitution." Cooley, at 164. This is so because in exercising the authority to declare a statute unconstitutional judges are not claiming judicial supremacy; rather, "they are only the administrators of the public will. If an act of the legislature is held void, it is not because the judges have any control over the legislative power, but because the act is forbidden by the constitution, and because the will of the people, which is therein declared, is paramount to that of their representatives expressed in any law." Cooley, at 160 (emphasis added).

In examining the constitutionality of a statute, the meaning of the constitutional provision against which the statute is to be measured is obviously of critical

importance. The foremost maxim of construction is that "The object of construction, as applied to a written constitution, is to give effect to the intent of the people in adopting it." Cooley, at 55 (emphasis in the original). This method of construction is a part of our jurisprudential history. The court is to "declare the law as written, leaving it to the people themselves to make such changes as new circumstances may require. The meaning of the constitution is fixed when it is adopted, and it is not different at any subsequent time when a court has occasion to pass upon it." Cooley, at 55. As Justice Campbell put it in People v Blodgett, 13 Mich 127, 138 (1865): "The meaning of our constitution was fixed when it was adopted, and the question which is now before us is not different from what it would have been had the constitution been recently adopted....Constitutions cannot be changed

by events alone. They remain binding as the acts of the people in their sovereign capacity, as the framers of government, until they are amended or abrogated by the action prescribed by the authority which created them." See also Justice Scalia, concurring in Minnesota v Dickerson, 124 L Ed 2d 334, at 348 (1993): it is a "fundamental principle of constitutional adjudication that the terms in the Constitutin must be given the meaning ascribed to them at the time of their ratification." This does not mean that the constitution is "static" in that it cannot be applied to unforeseen events or developments (such as modern technology)--surely, its principles can be applied to new situations, as Justice Campbell recognized over 125 years ago: "That the constitution means nothing now that it did not mean when it was adopted, I regard as true beyond doubt. But it must be

regarded as meant to apply to the present state of things as well as to all other past or future circumstances." Blodgett, at 140 (emphasis added). But the principles do not change--the constitution does not change to meet the times--the constitution is simply capable of application to new circumstances.

II. THE DUE PROCESS QUESTION

> "...there is simply no avoiding the fact that the word which follows "due" is "process"....we apparently need periodic reminding that 'substantive due process' is a contradiction in terms--sort of like 'green pastel redness.'"
>
> John Hart Ely, Democracy and Distrust (Harvard University Press, 1980), p.18.

The Analytical Approach

> "Well, what may seem like the truth to you," said the seventeen-year-old bus driver and part-time philosopher, "may not, of course, seem like the truth to the other fella, you know."
>
> "THEN THE OTHER FELLOW IS WRONG, IDIOT!"
>
> Philip Roth, The Great American Novel (1973), p.19.
>
> "...it by no means is true that every law is void which may seem to the judges who pass upon it excessive, unsuited to its ostensible end, or based upon conceptions of morality with which they disagree....Otherwise a constitution...would be become the partisan of a particular set of ethical or economical opinions, which by no means are held semper ubique et ab omnibus.
>
> Otis v Parker, 187 US 606, 47 L Ed 326 (1902) (Justice Holmes, for the Court)

The attack on the prohibition on assisted suicide generally proceeds by a series of logical progressions, essentially as follows: 1)the Constitution prohibits deprivation by the Government of an individual's life, liberty, or property without Due Process of law; 2)a concept of "personal autonomy" may be located within

the "liberty" protected by the Constitution; 3)that concept of personal autonomy includes a person's ability to control his or her own body--to make "basic decisions regarding bodily integrity"; 4)that ability to control one's own body and make basic decisions regarding bodily integrity includes the liberty to terminate one's life; 4)a prohibition on the liberty interest of self-destruction is therefore unconstitutional (rather than subject to deprivation only upon "Due Process"). It is more than passing strange that under the Due Process Clause one's very life may be taken by the Government, certainly against his or her will, so long as fair procedures are employed, but an alleged aspect of one's right to liberty may not, no matter what the procedure. How can this be? From where does this liberty interest arise that is superior to one's right to live?

One thing is clear: an "undeprivable

even with Due Process" right to liberty/personal autonomy/control of one's body/to commit suicide (and to assist someone in so doing) can be found neither in the text of the Constitution, nor in the history of our Nation, which has never countenanced assisted suicide. It comes, rather, from the belief of those who think it the right, or correct, or moral thing, and must be "constitutionalized" by them to protect it against those to whom it "may not, of course, seem like the truth," because those people, even if they happen to include the democratically elected lawmakers of the society, are simply wrong.

This approach, of course, allowed Chief Justice Taney to declare that there could be no valid law against slaveholding in the United States, slaveholders having a liberty (as well as property) interest in owning slaves with which the Government could not interfere. How did Chief Justice Taney know

this liberty interest existed, it not being stated in the Constitution? He knew it because he was passionately convinced that it must be so. Dred Scott was not decided on the basis of history and tradition giving rise to a liberty interest in slave holding, as history and tradition would not support such a finding, slavery being prohibited in much of the country. It was the prevention of action by the democratically elected legislature--a ursupation of authority by the judiciary--by proclaiming that the legislature was without power to ban slavery in the territories through the finding of a liberty interest in the slave holder which helped precipitate the Civil War. Dred Scott was decided on the Respondents' defendant's theory of constitutional adjudication; that is, that the Constitution is an empty vessel into which the judiciary may pour whatever meaning it chooses, the object of the parties to constitutional

disputes being to convince the court as to which side has the better moral philosophy.

Respondents can offer no principle by which statutes prohibiting assisted suicide may be overturned which would in any way serve as a check on the personal predilections of the judiciary. In short, the approach of the Respondents and the courts below is simply moral philosophy, attempting to engraft a particular moral philosophy into the Constitution, and as Professor Ely has said, "our society does not, rightly does not, accept the notion of a discoverable and objectively valid set of moral principles, at least not a set that could plausibly serve to overturn the decisions of our elected representatives." Because history and tradition demonstrate that there is no constitutional right to assisted suicide does not disable the legislature from deciding to allow the practice. It is a finding of

unconstitutionality which freezes tradition and history, which ends debate on the matter, not a finding of constitutionality, which allows the democratic process to continue to work.

The Constitution not properly being a flag to be captured by whomever can persuade a majority of Justices as to their view of moral philosophy, thereby completely shutting out competing views, what approach is to be taken as a matter of law and not philosophy to identification of liberty interests? Palko v Connecticut, 302 US 319, 82 L Ed 288 (1937) demonstrates the method.

Today, the doctrine of "selective incorporation" of the Bill of Rights has captured the field as to most of the rights protected by the Bill of Rights, so that it is held that the "Due Process" required by the 14th Amendment of the States includes most of the Bill of Rights. But before selective incorporation there was Palko, and

the approach of Palko is still valid with regard to claims of liberty interests or procedural protections not contained within the Bill of Rights. In that case the defendant was found guilty of murder in the second degree after a trial for first degree murder, and the state appealed, as was allowed under Connecticut law. On appeal it was found that error had been committed in excluding the defendant's confession, in excluding testimony to impeach his credibility, and in instructing the jury on the difference between first and second degree murder. Palko was retried, convicted of first degree murder, and sentenced to death. He claimed that jeopardy precluded the retrial which he had not sought.

Because the Bill of Rights, and therefore the jeopardy provision, was not (then) applicable to the States, the Court looked to the Due Process Clause of the 14th Amendment to see if the practice of

Government appeal and retrial offended that clause. The Court stated that those protections which may be found to be "implicit in the concept of ordered liberty" are applicable to the States through Due Process requirements. A liberty interest or procedural protection exists if "so rooted in the traditions and conscience of our people as to be ranked fundamental." In the case before it the Court concluded that because the state was not "attempting to wear the accused out by a multitude of cases with accumulated trials," but instead asking only that "the case against him shall go on until there shall be a trial free from the corrosion of substantial legal error," this was not "cruelty at all"; indeed, to allow the state an appeal with regard to trial error was, said the court, "no seismic innovation. The edifice of justice stands, in its symmetry, to many, greater than

before." 82 L Ed at 293-294.

As stated, the total incorporation/selective incorporation/no incorporation struggle with regard to the Bill of Rights has ended with the victory of selective incorporation, but for claims outside the Bill of Rights the Palko approach remains viable. Michael H. v Gerald D., 491 US 110, 105 L Ed 2d 91, 109 S Ct 2333 (1989) illustrates the point. The petitioner maintained an adulterous relationship with a married woman who was cohabiting with her husband, and a child was born, which was almost certainly his. The mother reconciled to her husband, and state law conclusively presumed that the issue of a wife cohabiting with her husband, who was not impotent or sterile, was the child of the marriage. The purpose of the statute was to protect the privacy and integrity of the family; the petitioner, however, wished to establish visitation rights with the

child, which he could only do by establishing paternity, which the law precluded. He claimed that the state statute was unconstitutional because he had a liberty interest in his relationship with his child.

The Court rejected the claim. The plurality opinion observed that the Court itself had previously expressed concern regarding the recognition of "new" liberty interests under Due Process claims, "lest the only limits to...judicial intervention become the predilections of those who happen at the time to be Members of this Court." Moore v East Cleveland, 431 US 494, 52 L Ed 2d 531, 97 S Ct 1932 (1977). As Justice White observed in dissent in Moore, "the present construction of the Due Process clause represents a major judicial gloss on its terms, as well as on the anticipation of the Framers..., the Court should be extremely reluctant to breathe still further

substantive content into the Due Process Clause so as to strike down legislation adopted by a State or city to promote its welfare. Whenever the Judiciary does so, it unavoidably pre-empts for itself another part of the governance of the country without express constitutional authority."

The approach cannot be one of personal predilection then, said the Court, so that "we have insisted not merely that the interest denominated as a 'liberty' be 'fundamental'...but also that it be an interest traditionally protected by our society," that it be "rooted in history and tradition." (emphasis supplied, 105 L Ed 2d at 105). Finding that the relation between persons in the situation of the petitioner and his child had not been protected under our historic practices (indeed, the historic tradition is the other way, to protect the integrity and privacy of the family), the Court rejected the claimed liberty interest.

See also Bowers v Hardwick, 478 US 186, 92 L Ed 2d 140, 106 S Ct 2841 (1986).

Moore v East Cleveland, cited above, itself also demonstrates the appropriate method. A housing ordinance limited occupancy of dwellings to members of a single family, and defined "family" as essentially only the "nuclear" family. A woman was convicted of violating the ordinance because she lived with her son and two grandsons, and the grandsons were not brothers but cousins. In dissent from the finding of unconstitutionality of the ordinance, Justice White expressed the concerns above noted regarding judicial usurpation of legislative authority under the auspices of the Due Process Clause, based on nothing other than the predilections of the Justices. Justice Powell, the author of the lead opinion, also appreciated this concern, agreeing that "there are risks when the judicial branch

gives enhanced protection to certain substantive liberties without the guidance of the more specific provisions of the Bill of Rights....there is reason for concern lest the only limits to such judicial intervention become the predilections of those who happen at the time to be Members of this Court....history counsels caution and restraint." How, then, to avoid decisions based only on a particular moral philosophy embraced by a majority of Justices? Justice Powell supplied the answer: "Appropriate limits on substantive due process come...from careful 'respect for the teachings of history (and) solid respect for the basic values that underlie our society.'" 52 L Ed 2d at 540. Addressing Justice White's dissent directly, Justice Powell stated that defining the substantive content of liberty interests to be found in the Due Process Clause by looking to "history and tradition" imposes "meaningful

limits" on the judiciary. 52 L Ed 2d at 540, fn 12 (emphasis added). While reasonable people may at times disagree as to what history and tradition demonstrate, at least they are engaged in the same enterprise, and where history and tradition point in a certain direction, judges are not free to disregard it in favor of their own views of moral philosophy or ethical values.

Cruzan v Director, Missouri Department of Health,, 497 US 261, 111 L Ed 2d 224, 110 S Ct 2841 (1990) in no way supports the circuit courts' usurpations of legislative authority; indeed, read properly, it virtually compels the opposite conclusion. The claimed liberty interest there was a right to refuse life-sustaining medical intervention, and more precisely, whether the decision of the State that it must be demonstrated by convincing evidence that the individual who is being treated would desire the cessation of treatment was

constitutional. The Court looked again to history and tradition. It is in our tradition that the touching of another person, including through medical treatment, without permission, or "informed consent," is a battery, which can lead to damages. As the Court observed, the "logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." 111 L Ed 2d at 236. The Court specifically declined to view the matter as involving a generalized constitutional right of privacy, analyzing the question instead in terms of a liberty interest to avoid unwanted touching or intervention upon one's body, and looking to history and tradition. The Court concluded in the end that this liberty interest can be regulated by the State with process that is "due," and held that requiring a showing of convincing evidence was not improper, or "undue." On

its way to this conclusion the Court discussed the State's interest in the matter, noting in support of the State's interest that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." 111 L Ed 2d at 243. How possibly could the Court have looked to the fact that the majority of states have laws imposing criminal penalties for assisted suicide as a factor in favor of the State's interest on the issue of terminating medical care if those state laws are in fact unconstitutional? Cruzan provides no support for the circuit court decisions, but mandates the conclusion that theyerred egregiously.

The Casey Decision

Respondets, as well as the circuit court decisions, rely heavily on the triune joint opinion in Planned Parenthood v Casey, 120 L Ed 2d 674 (1992). The decision,

however, plays them false. Casey, albeit in a way previously unknown in jurisprudence, "retained" the "essential holding of Roe v Wade...." (retained in a way previously unknown in jurisprudence in that the joint opinion also modified the "essential" holding of Roe v Wade, see Justice Scalia, dissenting, at 120 L Ed 2d at 791: "I confess never to have heard of this new, keep-what-you-want-and-throw-away-the-rest version" of stare decisis). The opinion threw out the trimester approach of Roe in favor of a viability approach; that is, it held that the State may absolutely prohibit abortions, save when necessary to save the life or health of the mother, after fetal viability. Thus, once the fetus has attained the degree of development that the Court is willing to recognize as "life," the interest of the State in protecting life outweighs the interest of personal autonomy, so that the State may prevent the abortion.

See 120 L Ed 2d at 710. Even before viability, the State's "profound interest" in what the opinion called "potential life" allows regulation, so long as an undue burden is not placed on the decision to obtain an abortion, an "undue burden" being a provision of law the purpose of effect of which is to place a "substantial obstacle" in the path of a woman seeking an abortion "before the fetus attains viability." 120 L Ed 2d at 715. At viability, however, the State's interest overtakes the individual liberty interest created in Roe, and nontherapeutic abortions may be prohibited.

This does not advance the respondents' cause, for even abortion law, then, recognizes an overwhelming State interest in protecting life that has reached that form which the Court is willing to recognize, which, in the case of a fetus, is viability, that state of development where the fetus could survive outside the womb. If the

State's "profound interest" in protecting life overtakes the right of liberty created in Roe, how can it possibly be said that it ends at some point after birth? The interest of the State is surely at least as profound after birth as at viability, as history teaches. The only possible answer of the respondents is that life may reach a point where it should not be considered life--it should be defined "out of" life--for it has become "not worth living." But this question of moral philosophy is one to be debated before legislatures, not one for the imposition of a particular answer by judges, and history teaches that the concept of a life not worthy to be lived is a dangerous notion indeed. Casey supplies no succor to respondents.

Tradition and Assisted Suicide

Do, then, our traditions and our history recognize a right to suicide, and to assist another in its commission (leaving

aside whatever the history and traditions of other nations, such as Greece and Rome, reveal)? Clearly not, as the Court of Appeals recognized. In England, suicide was a form of common law murder, described as either self-murder, see 3 Coke, Institutes Of The Laws of England 54 (1797), 4 Blackstone, Commentaries 189, or the decedent being deemed "the murderer of himself." W Clark and W Marshall, A Treatise On The Law of Crimes, sec. 10.03, at 623 (7th Ed, 1967). It was punishable by burial in the highway with a stake through the suicide's body and forfeiture of all his goods to the crown. According to Blackstone, common law felonious homicide occurred "when a person of sound memory and discretion, unlawfully killeth any reasonable creature in being, and under the king's peace, with malice aforethought, either express or implied." Blackstone specifically stated that murder may be

"either by killing one's self, or another man." 4 Blackstone, Commentaries, 188, 195.

Suicide is no longer considered criminal, but not because the act does not fall within the definition of murder, but because no punishment is provided for self-murder. Forfeiture of all property and burial in the highway with a stake through the suicide's body is no longer considered appropriate. This change was accomplished not to legitimize the act of suicide, but to spare the family of the suicide. See e.g. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional," Hastings Center Report 23, no. 3, p.32 (1993). However, aiding a suicide still falls within the common law definition of murder, and, where there is no other specific offense for the crime of assisted suicide, is therefore punishable according to the ordinary statutory penalties. The position taken by some that because neither suicide nor attempted

suicide are criminalized that it is therefore "logically incomprehensible" to charge a person with aiding and abetting a "lawful act," is wholly unpersuasive; indeed, Professor LaFave has derided the view that because suicide is no longer punished assisted suicide is also not criminal as "most certainly unsound." 2 LaFave and Scott, Substantive Criminal Law, sec. 7.8(c), at 249 (1986). The most celebrated model code with regard to criminal law, the Model Penal Code, not only prohibits assisted suicide in sec. 210.5, but grants a privilege to those who use force to prevent a suicide. See sec. 3.07(5). The Code was drafted after years of study, by the most eminent criminal law scholars, and itself is proof that there has not existed a historically recognized right to commit suicide or to assist in a suicide. See Kamisar, at 33.

Moreover, at the time of the ratification of 14th Amendment 21 of the 37 existing states, and 18 of the 30 ratifying states, prohibited assisted suicide. And even those states which had not spoken to the issue in 1868 held that assisted suicide was unlawful when the issue was faced. See Marzen, O'Dowd, Crone, and Balch, "Suicide: A Constitutional Right?," 24 Duquesne L Rev 1, 76-100, 148-242 (1985). It can readily be said that there is no significant support whatever for any claim that a right to suicide, or to assist in suicide, is "so rooted in our tradition that it may be deemed fundamental or implicit in the concept of ordered liberty."

There is not in this country, then, a tradition protecting suicide or assisted suicide. The question is one for the political branches of government.

Conclusion

> "It is precisely historical practices that define what is 'due.' 'Fundamental fairness' analysis may appropriately be applied to departures from traditional American conceptions of due process; but when judges test their individual notions of 'fairness' against an American tradition that is deep and broad and continuing, it is not the tradition that is on trial, but the judges."
>
> Justice Scalia, concurring in Schad v Arizona, 115 L Ed 2d 555 (1991)

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* See Alexander Bickel, The Supreme Court and The Idea Of Progress (Yale University Press: 1978), p. 84: "The independence of the judges is an absolute requirement if individual justice is to be done....But supreme judicial autonomy, the judge answerable only to his own conscience in making policy for the society, in adjusting, conformably to one or another choice of values, the conflicting interests, desires, and ethical and moral aspirations and preferences of the groups that constitute the society--that is something else again...."

The claim that assisted suicide is protected by the Due Process Clause fails as a matter of history and tradition, and fails in its attempt to broadly state the right as a right of "personal autonomy," which does not exist. There are particular rights of personal autonomy, such as the right not to be seized under the Fourth Amendment absent probable cause or reasonable suspicion, but a general right to personal autonomy is a right to be free of all law. The line-drawing the decisions of the circuit courts would require is classic judicial legislation. If there is a right to personal autonomy which includes a right to self-destruction, how can it possibly be limited? Why would not a person simply tired of life have a right to "blow his brains out" or drown him or herself without interference by the state? And if there is a right of personal autonomy, which includes

the right to control one's own body and make basic decisions regarding bodily integrity, why does it not include a right of consenting adults to engage in acts of incest? Why does it not include the right of a competent minor to engage in sex with an adult (how can statutory rape exist as a crime where the act is consensual?). Why does it not include the right to polygamous marriages? Why does it not include the right to take psychotropic drugs for recreational purposes? Why can an individual who causes harm to him or herself be committed to an institution as a threat to him or herself?

The "right" which has been invented by the circuit courts here is rife with line-drawing impossibilities. Could it possibly be plainer that if a right of "personal autonomy" as recognized by the circuit court exists then then a right to suicide must include all of "us"--it cannot

be said that it does not extend to those that are suffering physical pain but are not terminally ill, that it does not extend to those that are suffering "psychic" pain but are not physically ill at all, that it does not extend to anyone for any reason whatsoever. Further, any attempt at linedrawing necessarily involves the government in determining whether a life is "worthy to be lived." If the right is invented and limited to the terminally ill, when does it come into being? We are terminal from the moment of conception; when a specific illness has overtaken us, so that our death is reasonably predictable, does the "right" exist 3 months from death, 6 months from death, one year from death, five years from death? Does it not exist for those who are terminally ill, but who are not suffering great pain, and who determines whether pain is being suffered, and its degree? If the "right" belongs only to the

terminally ill who are suffering, by whatever standard, how can it be denied to those who are suffering "psychic" pain? How can a court possibly arrogate to itself the right to tell these people that though "The power to determine the limits to which one can endure pain and agony is certainly intrinsic to this basic concept of personal autonomy," it does not belong to them, so that rather than being treated (as many are, to full recovery) they should simply be assisted in achieving their deaths. As Professor Kamisar has observed, "if a competent person comes to the unhappy conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not 'qualify' under somebody else's standards? Isn't this an arbitrary limitation of self-determination and personal autonomy? 'How,' asks Daniel Callahan, 'can self-determination have any

limits? Why are not the person's desires or motives, whatever they be, sufficient?'" Kamisar, at 37. The People have simply not spoken on this question through the Constitution, and thus it is for the legislature.

Moreover the concern, expressed by Professor Kamisar, that "In a climate in which suicide is the 'rational' thing to do, or at least a 'reasonable' option," that it will "become the unreasonable thing not to do? The noble thing to do?....how likely is it that an old or ill person will be encouraged to spare both herself and her family the agony of a slow decline, even though she would not have considered suicide on her own?" is certainly legitimate. In this vein, amicus would point out that time and again the enactment and application of prohibitions on assisted suicide has been compared by one practitioner of this assistance to "Germany in the 1930's and

1940's," it being said that officials there and then also said they were "just following the law." This is bad logic, bad law, and bad history. Atrocities occurred in Germany not because people "followed the law," but because the law broke down; the nation of Germany was ruled by the cult of personality, by one who thought his notions of moral philosophy superior to all others, and who had the military power to put his philosophy into action. Those who committed atrocities in his name did not "follow the law," they followed orders. It was the suppression of democracy in favor of a "power elite" which was, in its view, above the law, which led to the Holocaust.

An article published in 1949 is also instructive in this regard. The article is "Medical Science Under Dictatorship," 241 New England Journal of Medicine 40 (1949). The article examines the question of how respected men of science--physicians--could

have engaged in atrocities under Nazi rule. The article, being published in 1949, has nothing to do with assisted suicide, not being written by a "partisan" of one side or the other of this question of moral philosophy and policy, but being concerned with physician atrocities during the War. The author concluded:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthenasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was

> the attitude toward the nonrehabilitable sick.

241 N Eng Jrnl of Med at 44 (emphasis added).

As stated earlier, Justice Cooley long ago correctly observed that in exercising the authority to declare a statute unconstitutional judges are "only the administrators of the public will. If an act of the legislature is held void, it is not because judges have any control over the legislative power, but because the act is forbidden by the constitution, and because the will of the people, which is therein declared, is paramount to that of their representatives expressed in any law." Cooley, at 160 (emphasis added). History clearly teaches us that the people have not expressed their will in the constitution that assisted suicide be protected, and there is thus nothing in the constitution which is paramount to the decision of the people's elected representatives, in our

constitutional democracy, to continue to prohibit it.

The "right" sought to be pounded into the Constitution by the lower courts simply cannot be found there, but is one which must be sought in the political arena, there being no principled basis upon which to locate it in the Due Process Clause. It can only be found there when judges assert their personal and individual predilections as being law. To conclude by reiterating Professor Ely: "...reasoning about ethical issues is not the same as discovering absolute ethical truth...our society does not, rightly does not, accept the notion of a discoverable and objectively valid set of moral principles, at least not a set that could plausibly serve to overturn the decisions of our elected representatives." This court should reverse the circuit courts.

Epilogue

"...(suppose) a statute making it a crime for any person to remove another person's gall bladder, except to save that person's life. Surely....that has to be unconstitutional...."

"I don't think that law is unconstitutional....If it passed, I think we could get it repealed pretty quick."

"What if we couldn't?"

"Then I'd suppose my elected representatives had found something about gall bladders that you and I are unaware of."

"Suppose they hadn't. Suppose they were just acting crazy."

"Vote them out. Impeach them. Repeal the law."

"Can't. Most people believe they're doing the right thing."

"And they're just acting crazy too?"

"Right."

"I don't suppose we can reason with them?"

"Nope."

"You know what you're telling me? That you don't believe in democracy."

Ely, at 182 (emphasis added).

RELIEF

Wherefore, amicus respectfully submits that the circuit courts should be reversed.

Respectfully submitted,

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne

TIMOTHY A. BAUGHMAN
Chief of Research,
Training and Appeals

MOTION FILED

DEC 9 1996

Nos. 95-1858
96-110

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1995

DENNIS VACCO, Attorney General
Petitioner

v

TIMOTHY QUILL, M.D. (and others)
Respondents

STATE OF WASHINGTON
Petitioner

v

HAROLD GLUCKSBERG
Respondent

ON CERTIORARI TO THE SECOND AND NINTH CIRCUIT COURTS OF APPEAL

MOTION TO FILE BRIEF AS AMICUS CURIAE ON BEHALF OF WAYNE COUNTY, MICHIGAN, IN SUPPORT OF THE PETITIONERS, OUT OF TIME

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne

*TIMOTHY A. BAUGHMAN
Chief of Appeals
1441 St. Antoine
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*counsel of record

MOTION TO FILE AS AMICUS CURIAE OUT OF TIME

NOW COMES Wayne County, Michigan, by John D. O'Hair, the Prosecuting Attorney of the County of Wayne, and Timothy A. Baughman, Chief of Research, Training and Appeals, and requests permission to file as amicus curiae in support of the petitioners out of time, as as reasons says as follows:

1. Amicus Wayne County has stated the reasons for filing as amicus in the brief itself.

2. The brief has itself been filed, and no delay will be occasioned in its consideration or review by the Court.

3. The brief was filed two days after the time for filing by the Petitioners, and an

amicus must file within the time for filing of the party supported. Regrettably, counsel for amicus was unaware of the expedited schedule for filing set for the parties, and apologizes for the delay in filing.

RELIEF

Wherefore, amicus respectfully requests that the motion to file as amicus out of time be granted.

Respectfully submitted,

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne



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No. 96-110

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1996

STATE OF WASHINGTON and CHRISTINE O. GREGOIRE, ATTORNEY GENERAL OF THE STATE OF WASHINGTON,
Petitioners,
v.
HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.
Respondents.

On A Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

BRIEF FOR JOHN DOE AS AMICUS CURIAE SUPPORTING RESPONDENT

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CONSENT OF PARTIES

All parties have consented to the filing of this Brief, and the letters stating that consent are attached.

INTEREST OF JOHN DOE

On September 20, 1996, John Doe obtained a judgment in the United States District Court for the Central District of California, Case No. 94-6089 CBM(Kx) declaring that

California Penal Code Section 401 is unconstitutional on its face because it violates the Due Process Clause of the Fourteenth Amendment to the United States Constitution. 939 F.Supp. 725. That Section, like RCW 9A.36.060, prohibits terminally ill individuals from obtaining assistance, even by licensed physicians, in ending their lives painlessly and with dignity.

The California Supreme Court interprets California Penal Code Section 401 to prohibit "participation in the events leading up to the commission of the final overt act, such as furnishing the means for bringing about death — the gun, the knife, the poison, or providing the water, for the use of the person who himself commits the act of self murder." *In Re Joseph G.*, 34 Cal.3d 429, 436, 194 Cal.Rptr. 163, 167 (1983). Under this interpretation, any physician who "aided, advised, or encouraged" John Doe in terminating his life would risk felony penalties in doing so; Penal Code Section 401 thus serves as an absolute prohibition on John Doe's exercise of this component of his right to liberty protected by the Fourteenth Amendment.

John Doe learned that he was HIV positive in 1984. Diagnosed with AIDS in January 1993, he is now in the advanced final stages of that disease and has been advised by his physician that his condition is terminal. With his immune system severely compromised (a CD4 count of 0), he now suffers from three debilitating diseases, each incurable.

The first to appear was Cytomegalovirus ("CMV") retinitis, a condition in which the virus attacks the optic nerve. Medication can slow the deterioration of his vision, but cannot prevent him from eventually going blind. For over a year he received that medication by injection directly into his eye, but now undergoes an experimental implant treatment. This virus causes death in a few weeks to months if it invades the brain or spinal cord.

In March, 1995, tests revealed that John Doe suffers from Mycobacterium Avium Complex ("MAC"), a bacterial infection. This causes chronic night sweats, fever, chills, malaise, nausea, and bone pain; it has been described as "the worst flu you ever had, every day of your life."

Also in March, 1995, a biopsy disclosed Kaposi's Sarcoma in the back of John Doe's throat. Patients with KS frequently die from invasion of this cancer into the lungs, causing progressive difficulty in breathing and ultimately death by suffocation.

Over the past year he has lost 35 lbs., 25% of his body weight. Neuropathy has confined him to bed 24 hours per day for the last 16 weeks. The CMV has spread to his other eye, and he suffers from pancreatitis and loss of kidney function. The fever, chills, etc. of MAC have persisted for the entire year. His *daily* medications, many of which cause significant unpleasant side-effects (e.g., nausea, diarrhea, kidney problems, feminization, impotence), now include Indinazir (an anti-viral for AIDS); Pyrazinamide (for MAC); Ethambutol (same); Biaxin (antibiotic); Dapsone (for MAC); Diflucan; Lamivudine (antiviral for AIDS); Vasotec (anti-hypertensive); AZT (for AIDS); Megestrol (appetite stimulant); Neupogen; Epogen (for white cell count); steroid shots; Percocet (pain relief); Vicodin; Foscarnet infusions (for CMV); nausea medication; and a morphine patch which he wears 24 hours a day.

AIDS patients typically die in a slow, prolonged, and extremely painful process. By the time that health care professionals agree that there is no hope for any meaningful quality of life and deem patients "end stage", patients are often emaciated beyond belief, reminiscent of starving individuals in Ethiopia or the dead photographed concentration camp victims from World War II. During this stage, patients usually lose control of all bodily functions, especially urination and defecation, and are rendered helpless, often

bed-bound, lying in their own excrement. Because of the multitude of opportunistic infections and AIDS-associated tumors, all end-stage AIDS patients can suffer from intractable pain.

John Doe has seen many of his peers end their lives in pain and degradation from the ravages of AIDS. Rather than suffer that fate, John Doe wants the ability to control his own final days. Whether the State of California can deny him that right, forcing him to prolong his suffering or restricting him to inherently more dangerous, painful, risky and often barbaric methods of suicide, will be controlled by this Court's ruling in these consolidated cases.

The opinion of the Ninth Circuit vindicates the rights of the terminally ill, such as John Doe, far more forcefully and eloquently than John Doe could in any Brief. John Doe is also confident that the briefing which this Court will receive on the merits from the parties and from other amici will be as thorough and instructive as is humanly possible. Notwithstanding his intense interest in the merits of this issue, John Doe will limit this Brief to a preliminary legal issue, namely the effect of challenging the constitutionality of a statute on its face. This issue was briefed in detail by both John Doe and the California Attorney General in Doe's action, and Doe believes that the authorities developed there would be helpful to this Court.

STATEMENT

John Doe adopts the statement of Respondents.

SUMMARY OF ARGUMENT

In footnotes 8 and 9 of the opinion below (79 F.3d at 797 n. 8, 798 n. 9), the Ninth Circuit addressed the nature of the challenge made to RCW 9A.36.060: whether that statute was void "on its face" or only "as applied". This issue arises

in numerous cases raising Constitutional issues and recent case authority has created a conflict in the Circuits.

Amicus John Doe submits that determining the type of challenge proper requires answers to four questions:

(1) Who has standing to challenge the Constitutionality of a statute?

(2) How much protected conduct must a statute reach before a court may declare it void "on its face"?

(3) What burden of proof must a plaintiff meet in order to obtain a declaration voiding a statute?

(4) What happens to a statute declared void?

While no one decision of this Court articulates the answers to all four questions, this Court's consistent practice over many years defines the guidelines for facial challenges. In general, these are that the plaintiff must be someone to whom the statute could not constitutionally apply; that the statute must reach a "substantial amount" of protected conduct; that the statute must create an undue burden on the exercise of a Constitutional right; and that if the offending portion of the statute cannot be severed, the entire statute should be declared void.

ARGUMENT

I.

BACKGROUND OF THE ISSUE

Any discussion of facial challenges to the constitutionality of a statute must begin with this Court's decision in *United States v. Salerno*, 481 U.S. 739, 107 S.Ct. 2095 (1987). In the course of its opinion, this Court stated that "A facial challenge to a legislative act is, of course, the most difficult challenge to mount successfully, since the challenger must

establish that no set of circumstances exists under which the act would be valid." 481 U.S. at 745, 107 S.Ct. at 2100.

Three Circuits have expressed uncertainty regarding the implications of this statement.[1] The Third, Eighth, and Ninth Circuits concluded that this Court did not follow this principle in *Planned Parenthood v. Casey*, 505 U.S. 833, 112 S.Ct. 2791 (1992) ("*Casey*"), and that facial challenges may be brought under a wider range of circumstances. The Fifth Circuit, in contrast, understood *Salerno* to control facial challenges. *Barnes v. Moore*, 970 F.2d 12, 14 n. 2 (5th Cir. 1992). Several members of this Court have commented on this issue in *Janklow v. Planned Parenthood, Sioux Falls Clinic*, ___ U.S. ___, 116 S.Ct. 1582, 134 L.Ed.2d 679 (1996); *Fargo Women's Health Organization v. Schafer*, 507 U.S. 1013, 1014, 113 S.Ct. 1668, 1669, 123 L.Ed.2d 285 (1993); and *Ada v. Guam Society of Obstetricians and Gynecologists*, 506 U.S. 1011, 113 S.Ct. 633, 121 L.Ed.2d 564 (1992).

Knowing when and how facial challenges may be brought is of considerable importance. Constitutional challenges to statutes are frequent, and both courts and parties deserve a clearly defined framework for the types of challenges which may be made.

This very case exemplifies some of the uncertainties which may arise:

> "Notwithstanding the District Court's declaration that the Washington statute is unconstitutional, the effect of its ruling is unclear. It is extremely unlikely that the

[1] *Compassion in Dying v. Washington*, 79 F.3d 790, 798 n. 9 (9th Cir. 1996); *Planned Parenthood, Sioux Falls Clinic v. Miller*, 63 F.3d 1452, 1456-8 (8th Cir. 1995); *Fargo Women's Health Organization v. Schafer*, 18 F.3d 526 (8th Cir. 1994); *Casey v. Planned Parenthood*, 14 F.3d 848, 863 n. 21 (3rd Cir. 1994).

district judge intended to strike down the entire statute, as the state asserts she did, in view of the fact that the appellants attacked only its 'or aids' provision. This is particularly true because the 'or aids' provision is clearly severable under Washington law. [Citation omitted.]

It is equally unclear whether the District Judge intended to strike the 'or aids' provision on its face or as applied. [Citation omitted.] Again, we think it unlikely that she intended to strike the entire provision for two reasons. First, the plaintiffs only argued that the assisted-suicide provision violated the constitutional rights of terminally ill, competent adults, and only offered evidence to that end. The parties did not address whether broader relief was permitted or required, and the District Court offered no explanation as to why a finding that the provision was unconstitutional as applied to the terminally ill would cause her to strike the provision on its face rather than as applied to the injured group.

* * *

Declaring a statute unconstitutional as applied to members of a group is atypical but not uncommon. *See, e.g., Tennessee v. Garner*, 471 U.S. 1, 11, 105 S.Ct. 1694, 1701, 85 L.Ed.2d 1 (1985) (holding that state law permitting police officers to use deadly force to prevent the escape of felony suspects was unconstitutional as applied to suspects who pose no immediate threat to officers or others); *Wisconsin v. Yoder*, 406 U.S. 205, 92 S.Ct. 1526, 32 L.Ed.2d 15 (1972) (holding Wisconsin's mandatory attendance law unconstitutional but only as applied to Amish children who have graduated from eight grade). Although the Court did not explicitly use the term 'as applied', it did explicitly affirm the judgment of the Wisconsin Supreme Court, *id.* at 207, 92 S.Ct. at 1529, which struck down the statute only as applied to Amish

children who had graduated from the eighth grade. *Wisconsin v. Yoder*, 49 Wis.2d 430, 182 N.W.2d 539 (1971).

Because we are not deciding the facial validity of RCW 9A.36.060, there can be no question that the exacting test for adjudicating claims of facial invalidity announced in *United States v. Salerno*, 481 U.S. 739, 107 S.Ct. 2095, 95 L.Ed.2d 697 (1987), is inapplicable here. ('A facial challenge to a legislative Act is, of course, the most difficult challenged to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act wold be valid.' *Id.* at 745, 107 S.Ct. at 2100). For that reason alone, we would reject Washington's suggestion that we use the *Salerno* test for adjudicating plaintiffs' constitutional challenge." *Compassion in Dying*, 79 F.3d at 797 n. 8 and 798 n. 9.

These passages from the opinion below, combined with a review of earlier decisions by this Court, aid in identifying the critical issues:

(a) What rules of standing apply to facial challenges, *i.e.*, may such a challenge may be brought by persons to whom the statute *could* apply, or only by those to whom it could not?

(b) How extensive must the potential unconstitutional applications be in order to justify a facial challenge rather than one "as applied"?

(c) What form should the relief take?

(d) What showing must be made in order to declare a statute unconstitutional?

While this Court has never articulated answers to these four questions in any one decision, express language in some opinions and the natural consequence of its holdings in numerous related cases provide those answers. John Doe

submits that those answers demonstrate this Court's consistent *rejection* of the dictum in *Salerno*.

II.

THE AUTHORITY CITED BY *SALERNO* ESTABLISHES ONLY A REQUIREMENT OF STANDING, NOT A TEST FOR ADJUDICATING FACIAL CHALLENGES

Salerno cited as authority the decision in *Schall v. Martin*, 467 U.S. 253, 269 n. 18, 104 S.Ct. 2403, 2412 n. 18 (1984). *Schall* contains no substantive discussion, but, in turn, cited *United States v. Raines*, 362 U.S. 17, 21-23, 80 S.Ct. 519, 522-3 (1960), which is thus the ultimate source authority for *Salerno*.

Raines was a criminal prosecution for interference with the right to vote. The defendants challenged the statute as beyond the power of Congress under the Fifteenth Amendment. The District Court dismissed the complaint in reliance on this Court's decision in *U.S. v. Reese*, 92 U.S. 214 (1876).

The statute in *Reese* had punished *all* interference with the right to vote, even that not resulting from racial discrimination. This Court held in *Reese* that Congressional power to enforce voting rights under the Fifteenth Amendment was limited to punishing discrimination on account of race. Because the statute exceeded Congress' power, it was unconstitutional and should not be applied even to those whom Congress could have punished under a narrower statute. 92 U.S. at 220-1.

Raines declined to follow *Reese*, holding that where the application of the statute was clearly constitutional in the particular case, the defendant could not complain that the statute might be applied unconstitutionally to others. 362 U.S. at 24-25, 80 S.Ct. at 524-5. This was a determination

of standing, not a rule affecting the merits of facial challenges.

Raines' concern with standing appears clearly from its reliance on and citation to *Barrows v. Jackson,* 346 U.S. 249, 73 S.Ct. 1031 (1953), a classic standing case. 362 U.S. at 21-2, 80 S.Ct. at 523. Also telling is the fact that *Raines* did not overrule *Reese* or even disapprove it. *Raines* declined to follow *Reese* not because *Reese* improperly applied the rules controlling facial challenges, but because this Court had developed rules of standing which made *Reese* inapplicable.[2]

Raines supports *Salerno* only to the extent that a uniform invalidity of the statute may be necessary to confer standing — application of a statute void in all applications perforce confers standing on the person to whom it is applied. But in *Raines* the statute manifestly was constitutional as to the particular defendants; *Raines* does not even address facial challenges in the opposite context, i.e., when, as here, a party alleges that he or she is within the class whose constitutional rights are violated. Such persons undoubtedly have standing to sue; whether *Salerno* states the proper test for the challenges they bring can only be derived, if at all, from other cases.

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[2]More liberal principles of standing can apply in some circumstances. E.g., *Edmonson v. Leesville Concrete Co., Inc.,* 500 U.S. 614, 628-9, 111 S.Ct. 2077, 2087 (1991); *Singleton v. Wulff,* 428 U.S. 106, 96 S.Ct. 2868 (1976); *Eisenstadt v. Baird,* 405 U.S. 438, 444-6, 92 S.Ct. 1029, 1033-5 (1972); *Barrows v. Jackson, supra; NAACP v. Alabama,* 357 U.S. 449, 459-60, 78 S.Ct. 1163, 1170 (1958). And see *Alexander v. U.S.,* 509 U.S. 544, 555, 113 S.Ct. 2766, 2774 (1993) (noting that the First Amendment overbreadth doctrine is an exception to the rule that those to whom a statute may apply lack standing to sue).

III.

THIS COURT'S CONSISTENT PRACTICE CONTRADICTS *SALERNO;* STATUTES WHICH REACH A SUBSTANTIAL AMOUNT OF PROTECTED CONDUCT MAY BE VOIDED IN THEIR ENTIRETY IF SEVERANCE OF THE OFFENDING PORTION IS NOT POSSIBLE

If *Raines* solves the standing issue, answers to the remaining questions — the extent of the unconstitutional impact, the showing necessary, and the relief which is appropriate — can be found by reviewing this Court's practice in deciding Constitutional issues. The most direct route to *Salerno* follows the path of the remedy appropriate in facial challenges.

When presented with a facial challenge to a statute brought by a party with standing to sue, this Court has several options available:

(a) It could declare the statute void.

(b) It could hold the statute void in the class of cases represented by the plaintiffs.

(c) It could treat the case as an "as applied" challenge and limit its ruling to the facts presented by the particular plaintiff(s).

In *Kolender v. Lawson,* 461 U.S. 352, 103 S.Ct. 1855, 75 L.Ed.2d 903 (1983), this Court specifically affirmed its power to declare statutes void *in their entirety* even if they could constitutionally be applied to some:

> "In his dissent, Justice WHITE claims that '[t]he upshot of our cases . . . is that whether or not a statute purports to regulate constitutionally protected conduct, it should not be held unconstitutionally vague on its face unless it is vague in all of its possible applications.' *Post,* at 1865. The description of our holdings is inaccurate in

several respects. First, it neglects the fact that we permit a facial challenge if a law reaches 'a substantial amount of constitutionally protected conduct.' Second, where a statute imposes criminal penalties, the standard of certainty is higher. This concern has, at times, led us to invalidate a criminal statute on its face even when it could conceivably have had some valid application. The dissent concedes that 'the overbreadth doctrine permits facial challenge of a law that reaches a substantial amount of conduct protected by the First Amendment . . . .' *Post,* at 1866. However, in the dissent's view, one may not 'confuse vagueness and overbreadth by attacking the enactment as being vague as applied to conduct other than his own.' *Post,* at 1865. But we have traditionally viewed vagueness and overbreadth as logically related and similar doctrines." 461 U.S. at 358 n. 8, 103 S.Ct. at 1859 n. 8, citations omitted.[3]

Kolender directly contradicts *Salerno.* Under *Kolender,* statutes which reach a substantial amount of protected conduct — a class certainly including RCW 9A.36.060 — may be declared void *in their entirety.* While this result must be considered in its proper context (see below), it is consistent with this Court's actions in numerous similar cases which, taken together, disclose the following circumstances under which statutes may be voided:

(1) Courts may strike down a statute as void for vagueness if persons of common intelligence must guess at its meaning, such that it fails to provide adequate notice of what conduct is forbidden or required. *Kolender*

[3]To anticipate one possible rejoinder to this language, *Salerno, supra,* 481 U.S. at 745, 107 S.Ct. at 2100, Doe notes that *Kolender* was not exclusively a First Amendment case, but also relied on the constitutional right to freedom of movement. 461 U.S. at 358, 103 S.Ct. at 1859. The examples cited below confirm that, in any event, this Court has never limited overbreadth challenges to First Amendment cases.

v. Lawson, supra; Lanzetta v. New Jersey, 306 U.S. 451, 59 S.Ct. 618 (1939).

(2) Courts may strike down statutes as "overbroad" when they have an inhibitory effect on free speech. *Broadrick v. Oklahoma,* 413 U.S. 601, 611-13, 93 S.Ct. 2908, 2915-16 (1973). Similarly, courts may strike down statutes as facially invalid if they violate the Establishment Clause. *Bowen v. Kendrick,* 487 U.S. 589, 600-602, 108 S.Ct. 2562, 2569-71, 101 L.Ed.2d 520 (1988); *Edwards v. Aguillard,* 482 U.S. 578, 107 S.Ct. 2573, 96 L.Ed.2d 510 (1987).

(3) Courts may strike down statutes which sweep unnecessarily broadly and thereby invade the area of protected freedom. *Griswold v. Connecticut,* 381 U.S. 479, 485, 85 S.Ct. 1678, 1682 (1965); *Roe v. Wade,* 410 U.S. 113, 164, 93 S.Ct. 705, 732, 35 L.Ed.2d 147 (1973); *Aptheker v. Secretary of State,* 378 U.S. 500, 844 S.Ct. 1659 (1964).

(4) Courts may strike down statutes which have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a non-viable fetus — the undue burden test of *Casey, supra.* And see *Zablocki v. Redhail,* 434 U.S. 374, 387, 98 S.Ct. 673, 681 (1978) (similar standard applied to protect marital relationship).

(5) Courts may strike down ordinances as regulatory takings if the ordinance does not substantially advance a legitimate state interest no matter how it is applied. *Yee v. City of Escondido,* 503 U.S. 519, 533-4, 112 S.Ct. 1522, 1531-2, 118 L.Ed.2d 153 (1992).

(6) Courts may strike down statutes as underinclusive on equal protection grounds even if those statutes would properly apply to some persons. *Orr v. Orr,* 440 U.S. 268, 271-2, 99 S.Ct. 1102, 1107-8, 59 L.Ed.2d 306 (1979).

And see *Kraft General Foods v. Iowa Dept. of Revenue*, 501 U.S. 71, 81-2, 112 S.Ct. 2365, 2371-2 (1992) (applying similar reasoning in finding violation of Foreign Commerce Clause); *Oregon Waste Systems, Inc. v. Dept. of Environmental Quality*, 511 U.S. 93, 114 S.Ct. 1345, 128 L.Ed.2d 13 (1994) (same under the Negative Commerce Clause); *Arkansas Writer's Project, Inc. v. Ragland*, 481 U.S. 221, 107 S.Ct. 1722, 95 L.Ed.2d 209 (1987) (same when discriminatory treatment affects First Amendment rights).

(7) Courts may strike down statutes where the valid provision is inextricably intertwined with the invalid one(s). See *Dorchy v. Kansas*, 264 U.S. 286, 290, 44 S.Ct. 323, 325 (1924); *Raines, supra*.

(8) Courts may strike down criminal statutes where the statute would require such a revision that it no longer gave intelligible warning of the conduct prohibited. *Raines, supra*, 362 U.S. at 22-3, 80 S.Ct. at 523.

(9) Courts may strike down statutes which are unconstitutional in the vast majority of their intended applications, and it can fairly be said that the statute was not intended to stand in only the remaining fraction of cases. See *Butts v. Merchants & Miners Transportation Company*, 230 U.S. 126, 33 S.Ct. 964 (1913); *Raines, supra*.

(10) Courts may strike down an unconstitutional part of a statute which is wholly independent of the constitutional part. *Allen v. Louisiana*, 103 U.S. 80, 83-4, 26 L.Ed 318 (1881); *Field v. Clark*, 143 U.S. 649, 695-6, 12 S.Ct. 495, 505-6, 36 L.Ed. 294 (1892); *Buckley v. Valeo*, 424 U.S. 1, 108, 96 S.Ct. 612, 677, 46 L.Ed.2d 659 (1976).

Taken as a whole, these cases demonstrate that this Court has followed a consistent practice of striking down in their entirety statutes which reach a substantial amount of protected conduct, when the statutes are challenged by persons

to whom they cannot constitutionally apply, *even if those statutes might constitutionally apply to others*. A review of the alternatives will demonstrate why this Court has acted so consistently in the examples cited above.

A. Challenges By Individual Plaintiffs Are Impractical.

The case before this Court is not one in which any ruling could be limited to the particular plaintiffs only. The very nature of the challenge identifies a large common class of similarly situated persons whose circumstances will differ only in detail from those of the plaintiffs here. Individuals who are terminally ill and suffering have no effective opportunity to protect their constitutional rights on a case by case basis because their medical condition precludes any active involvement in litigation. It would be exceedingly burdensome for each terminally ill patient to be forced to sue in order to exercise the fundamental right at issue here.

B. No Limiting Construction Is Available.

Taking the statute generally, one reason for voiding the entire statute is the lack of any basis for a limiting construction. RCW 9A.36.060 is a single section, accomplishing all of its results by the same general words. Like the ordinance at issue in *City of Houston, Texas v. Hill*, 482 U.S. 451, 107 S.Ct. 2502, 96 L.Ed.2d 398 (1987), Washington's law "is not susceptible to a limiting construction because . . . its language is plain and its meaning unambiguous. Its constitutionality cannot 'turn upon a choice between one of several alternative meanings.' [Citations omitted.] Nor can the ordinance be limited by severing discrete unconstitutional subsections from the rest." *Id.* at 468, 107 S.Ct. at 2513.[4]

[4]Although the issue of severability is for this Court to decide, *Wyoming v. Oklahoma*, 502 U.S. 437, 459, 112 S.Ct. 789, 803 (1992); *Dorchy v. Kansas, supra*, 264 U.S. at 291, 44 S.Ct. at 325, it is worth noting that Washington law treats the entire statute as inoperative when

C. Declaring A Judicially Created "Exceptions Clause" To The Statute Conflicts With Recognized Principles Of Severance And Intrudes On The Power Of The Legislature.

In *Tennessee v. Garner*, 471 U.S. 1, 11, 105 S.Ct. 1694, 1701, 85 L.Ed.2d 1 (1985), this Court applied the concept of "severance" in a somewhat unusual way by grafting an exceptions clause onto the statute. In so doing, it exempted an entire class from the operation of the statute.

While this approach would grant respondents satisfactory relief, and was the path taken by the Ninth Circuit (79 F.3d at 798 n. 9), Doe submits that better practice would be to declare the entire statute void as was done in, *e.g., Kolender, supra; Lanzetta, supra; Aptheker, supra; Casey, supra; Zablocki, supra; Griswold, supra; Orr, supra; Kraft General Foods, supra;* and *Oregon Waste Systems, Inc., supra.* This would accomplish two important results.

First, it would eliminate the possibility of any future inhibition on the exercise of constitutional rights which might exist because of the sweeping language of the statute. This Court expressed precisely this concern in the First Amendment overbreadth cases and in non-First Amendment cases such as *Kolender*, *Lanzetta*, and *Griswold*; the concern is clear but implied in *Casey* and *Zablocki*.

Of perhaps equal importance is that this Court has frequently recognized that unitary provisions cannot be severed. See, e.g., *Wyoming v. Oklahoma, supra*, 502 U.S. at 460, 112 S.Ct. at 803 (rejecting severability because "there are no parts or separate provisions in the invalid [section] of the Act .... Nothing remains to be saved once that provision is stricken. Accordingly, the Act must stand

---

the unconstitutional portion is inseparable from the rest. *In Re Hendrickson*, 12 Wash.2d 600, 123 P.2d 322, 326 (Wash. 1942).

or fall as a whole."); *U.S. v. Ju Toy*, 198 U.S. 253, 262 (1905) ("[T]he relevant portion being a single section, accomplishing all its results by the same general words, must be valid as to all that it embraces, or altogether void. An exception of a class constitutionally exempted cannot be read into those general words merely for the purpose of saving what remains."); *Illinois Cent. R.R. v. McKendree*, 203 U.S. 514, 529-30, 27 S.Ct. 153, 158-9 (1906).

The reason for this is clear: voiding the entire statute gives proper deference to the responsibility of the legislative branch. *Reese, supra*, recognized this principle, and its teaching on the effect of facial challenges, in contrast to its views on standing, should still be considered sound:

> "We are, therefore, directly called upon to decide whether a penal statute enacted by Congress, . . . which is in general language broad enough to cover wrongful acts without as well as within the constitutional jurisdiction, can be limited by judicial construction so as to make it operate only on that which Congress may rightfully prohibit and punish. For this purpose, we must take these sections of the statute as they are. We are not able to reject a part which is unconstitutional, and retain the remainder, because it is not possible to separate that which is unconstitutional, if there be any such, from that which is not. The proposed effect is not to be attained by striking out or disregarding words that are in the section, but by inserting those that are not now there. Each of the sections must stand as a whole, or fall altogether. The language is plain. There is no room for construction, unless it be as to the effect of the Constitution. The question, then, to be determined, is, whether we can introduce words of limitation into a penal statute so as to make it specific, when, as expressed, it is general only.
>
> *It would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and*

leave it to the courts to step inside and say who could be rightfully detained, and who should be set at large. This would, to some extent, substitute the judicial for the legislative department of the government. The courts enforce the legislative will when ascertained, if within the constitutional grant of power. Within its legitimate sphere, Congress is supreme, and beyond the control of the courts; but if it steps outside of its constitutional limitations, and attempts that which is beyond its reach, the courts are authorized to, and when called upon in due course of legal proceedings must, annul its encroachments upon the reserved power of the States and the people.

To limit this statute in the manner now asked for would be to make a new law, not to enforce an old one. This is no part of our duty." 92 U.S. at 221, emphasis added.

See also *Kolender*, *supra*, 461 U.S. at 358 n. 7, 103 S.Ct. at 1858 n. 7 (quoting the emphasized language favorably).

This Court's role in the government makes it preferable to void the statute and allow the Legislature to redraft it. Instead of an absolute prohibition, there would have to be a legislative definition of who was ineligible to exercise the right, the safeguards which might protect against its abuse, and approved principles or methods of carrying out the right. The Legislature deserves the opportunity to make these decisions in the first instance.

If, on the other hand, the statute remains in effect subject to piecemeal attack, the law is uncertain and the Legislature loses control over the process of designing a statute in accordance with democratic preferences. It also discourages the legislative branches from exercising their responsibility to evaluate the constitutionality of a statute before passage. This Court's respect for the process of legislation should dictate a policy of voiding unitary statutes which punish

protected conduct, letting the Legislature design a new statute in light of constitutional mandates.

IV.

CASEY'S "UNDUE BURDEN" TEST SETS THE CORRECT STANDARD OF PROOF

RCW 9A.36.060 clearly imposes an undue burden on the exercise of a fundamental privacy right. The same standard applied in *Casey* — which is the same standard this Court has applied in many cases — should apply here. Not only is the analogy with *Casey* compelling, but the importance of privacy as a component part of liberty, and the personal nature of privacy rights, requires that government actions not inhibit their exercise. In *Zablocki*, *supra*, this Court recognized that States could impose reasonable regulations which did not "significantly interfere" with the marital relationship. 434 U.S. at 386, 98 S.Ct. at 681. In applying this "undue burden" test without using that language, this Court stated:

> "Under the challenged statute, no Wisconsin resident in the affected class may marry in Wisconsin or elsewhere without a court order, and marriages contracted in violation of the statute are both void and punishable as criminal offenses. Some of those in the affected class, like appellee, will never be able to obtain the necessary court order, because they either lack the financial means to meet their support obligations or cannot prove that their children will not become public charges. These persons are absolutely prevented from getting married. Many others, able in theory to satisfy the statute's requirements, will be sufficiently burdened by having to do so that they will in effect be coerced into forgoing their right to marry. And even those who can be persuaded to meet the statute's requirements suffer a serious intrusion into their freedom of choice in an area in which we have held such

freedom to be fundamental." 434 U.S. at 387, 98 S.Ct. at 681, footnote omitted.

V.

CONCLUSION

This case, like John Doe's own case, does not require a search of the language or history of the Constitution for the phrase "physician aid in dying". Rather, it requires this Court to undertake its traditional role of breathing life and meaning into the term "liberty" as used in the Constitution. The process of construction by which this Court performs its judicial role can and should implement the intent of the American people to protect from government interference the right to make decisions central to human dignity and self-worth.

Statutes prohibiting physician aid in dying intrude drastically into the space of private decision-making protected by the guarantee of liberty. The effort to impose an absolute prohibition requires a remedy appropriate to the scope of the statute, and this Court should not hesitate to declare RCW 9A.36.060 invalid on its face.

DATED: December 09, 1996

Respectfully submitted,

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APPENDIX

[ATTORNEY GENERAL OF WASHINGTON SEAL]

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November 25, 1996

Mr. Mark E. Field
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Re: *Washington v. Glucksberg*,
U.S. Supreme Court Cause No. 96-110

Dear Mr. Field:

This responds to your request for consent to file a brief as *amicus curiae* in the above-referenced matter on behalf of John Doe. Your request for consent is granted.

Very truly yours,

/s/ WILLIAM L. WILLIAMS
William L. Williams
Sr. Assistant Attorney General

WLW:am

cc: Kathryn L. Tucker

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November 20, 1996

Mark E. Field
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Re: *Washington v. Glucksberg; Vacco v. Quill*

Dear Mr. Field:

This responds to your request to file a brief as amicus curiae in the above-referenced matters on behalf of John Doe. We understand that you intend to support the position of the Respondents. Your request for consent is granted. Consistent with our position throughout this litigation, we do not plan to share argument time with amici.

Please find enclosed a copy of the Court's order setting forth the briefing schedule for your information.

Also, please note that the joint appendix in *Washington v. Glucksberg* will be posted on the Attorney General's Office home page (http://www.wa.gov/ago) in a PDF format when it has been completed. To download it, you will need a program entitled Acrobat Reader, which can be downloaded free of charge from the Adobe home page (hhtp://www.adobe.com). In the meantime, the Complaint and significant briefing in support of Respondents in *Washington v. Glucksberg* is currently available on the Perkins Coie home page (hhtp://www.perkinscoie.com). We hope this medium will allow interested parties expeditious access to these materials and at the same time avoid unnecessary printing and mailing costs.

Thank you for your support of Respondents' position. We look forward to receiving a copy of your brief.

Very truly yours,

/s/ KATHRYN L. TUCKER
Kathryn L. Tucker

KLT:rak
Enclosure

cc: William L. Williams
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No. 96-110

In the Supreme Court

OF THE

United States

OCTOBER TERM, 1996

STATE OF WASHINGTON AND CHRISTINE O. GREGOIRE, ATTORNEY GENERAL OF THE STATE OF WASHINGTON,
Petitioners,

vs.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D. AND PETER SHALIT, M.D. PH.D.,
Respondents.

On A Writ of Certiorari To The United States Court of Appeals For the Ninth Circuit

MOTION FOR LEAVE TO FILE OUT OF TIME BRIEF FOR JOHN DOE AS AMICUS CURIAE

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On A Writ of Certiorari To The United States Court of Appeals For the Ninth Circuit

MOTION FOR LEAVE TO FILE OUT OF TIME BRIEF FOR JOHN DOE AS AMICUS CURIAE

John Doe requests leave of Court to accept for filing out of time the Brief for John Doe as Amicus Curiae Supporting Respondent. The Brief was received for filing by this Court on December 12, 1996, postmarked and served on all parties on December 9, 1996. John Doe's counsel was unaware that, due to an expedited filing schedule, Rule 29.2, which allows

a document to be considered filed as of the date of the postmark, was not applicable.

DATED: December 20, 1996

Respectfully submitted,

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